DOCUMENT RESUME

ED 164 828 CE 018 605

AUTHOR Moore, Donald E., Jr., Ed.
TITLE Proceedings: Mandatory Continuing Education. Prospects and Dilemmas for Professionals (University of Illinois at Urbana-Champaign, February 26-27, 1976).
INSTITUTION Illinois Univ., Urbana. Office of Continuing Education and Public Services.
PUB DATE Feb 76
NOTE 160p.

EDRS PRICE MF-$0.83 HC-$8.69 Plus Postage.
DESCRIPTORS *Certification; Conference Reports; Higher Education; Job Skills; Pharmacy; Professional Associations; *Professional Continuing Education; Professional Personnel; Program Administration; Program Development; Quality Control; Skill Obsolescence; *Standards

ABSTRACT

The papers compiled here were presented at a conference held for professionals from many fields to enable them to explore issues regarding mandatory continuing education. The papers are presented in six sections. The first is the introduction, while the keynote address, "Change, the Professions, and Continuing Education," comprises section 2. Section 3, "The Professions and the Public: External Pressures for Mandatory Continuing Education," contains seven papers. Some representative titles from this section are "Professional Services and Quality: Continuing Education as a Guarantee," "Licensing and the Consumer," and "Competency-based Relicensure." Seven papers comprise the next section, covering professional associations, professional schools, and continuing education. The following are some representative titles of these papers: "The Professional Schools, The World of Practice, and Continuing Education," "The Impact of Mandatory Continuing Education Requirements on Professional Associations," and "Accreditation of Continuing Education Programs for Professionals." Section 5 on mandatory continuing education and higher education is comprised of six papers and includes the following titles: "Mandatory Continuing Education and Professionals: The Responsibilities of Post-Secondary Institutions" and "Impact on Mandatory Continuing Education on the Program Development Process." The last section contains one paper, "Mandatory Continuing Education for Professionals: Implications for the Future." (EM)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED164828

PROCEEDINGS

Mandatory Continuing Education:

Prospects and Dilemmas
for Professionals

Editor, Donald E. Moore, Jr.

February 26-27, 1976

Office of Continuing Education and Public Service
University of Illinois at Urbana-Champaign

CE018 605

U.S. DEPARTMENT OF HEALTH,
EDUCATION & WELFARE
NATIONAL INSTITUTE OF
EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

Preface

We are pleased to share these conference proceedings. This set of conference papers provides some varied viewpoints on an issue in continuing education. We conducted the conference to impartially explore the issues and enable participants from many professional fields to meet, listen, and discuss. The nearly 200 participants indicated in their post-conference evaluation comments that they very much valued the opportunity for interchange.

Conferences similar to the one we conducted in February have since been held elsewhere. The discussion they encourage helps to provide a balanced examination of this issue and others important to the vitality of continuing professional education. We hope that these papers contribute useful background for such ongoing efforts.

My personal thanks to Donald Moore and the planning committee for conducting a successful conference.

Alan B. Knox
Director
Office of Continuing Education
and Public Service

TABLE OF CONTENTS

Page

I. INTRODUCTION
Donald E. Moore, Jr. 1

II. CHANGE, THE PROFESSIONS, AND CONTINUING EDUCATION
John E. Corbally, Jr. 6

III. THE PROFESSIONS AND THE PUBLIC: EXTERNAL PRESSURES FOR MANDATORY CONTINUING EDUCATION 12
R. Robert Geake, "Professional Services & Quality: Continuing Education as A Guarantee". 13
Robert C. Derbyshire, "Relicensure, Mandatory Continuing Education and The State Regulatory Agency" 24
Celia A. Maloney, "Licensing and The Consumer" 31
Jerry S. Dobrovolny, "Professional Engineer Requirements and The Role of Continuing Education". 35
Robert K. Richards, "Competency-based Relicensure" 40
Philip E. Frandson, "Greater Role for Universities in Setting Standards for The Professions" 48
C. Dale Greffe, "Problems in The Administration of Mandatory Continuing Education Requirements". 52

IV. PROFESSIONAL ASSOCIATIONS, PROFESSIONAL SCHOOLS, AND CONTINUING EDUCATION 56
Daniel C. Drucker, "The Professional Schools, The World of Practice, and Continuing Education". 57
William K. Selden, "Professional Standards, Competency, and Continuing Education: Roles and Responsibilities of Professional Associations" 62
William J. Greek, "The Impact of Mandatory Continuing Education Requirements on Professional Associations". 70
Clarke W. Mangum, Jr., "An Alternative to Mandatory Continuing Education: The AMA Physician's Recognition Award". 74
Jeanne Burson, "Accreditation of Continuing Education Programs for Professionals: 86
Ruth I. Heinemann, "Impact of Mandatory Continuing Education On a Professional School" 91
Diane J. Fisher and Marvin Weinstein, "Three Decades of 'Continuing Competence' in Pharmacy: An Interpretive Review" 94

V. MANDATORY CONTINUING EDUCATION AND HIGHER EDUCATION 113
Morton W. Weir, "Mandatory Continuing Education and Professionals: The Responsibilities of Post-Secondary Institutions" 114

Table of Contents, continued

Page

Cyril O. Houle, "Evidence for The Effectiveness of Continuing Professional Education and the Impact of Mandatory Continuing Education". 122
Floyd C. Pennington, "Impact on Mandatory Continuing Education on The Program Development Process" 128
John Thorpe, "Systems for Delivering Continuing Education" . . . 136
Jacqueline Schudel, "Impact of Mandatory Continuing Education on A Staff Development Program" 142
Robert P. Means, "Assessing Needs for Continuing Education". . . 147

VI. IMPLICATION FOR THE FUTURE 149
Alan B. Knox, "Mandatory Continuing Education for Professionals: Implications for The Future". 150

Table of Contents, continued

Page

Cyril O. Houle, "Evidence for The Effectiveness of Continuing Professional Education and the Impact of Mandatory Continuing Education". 122

Floyd C. Pennington, "Impact on Mandatory Continuing Education on The Program Development Process" 128

John Thorpe, "Systems for Delivering Continuing Education" . . . 136

Jacqueline Schudel, "Impact of Mandatory Continuing Education on A Staff Development Program" 142

Robert P. Means, "Assessing Needs for Continuing Education". . . 147

VI. IMPLICATION FOR THE FUTURE 149

Alan B. Knox, "Mandatory Continuing Education for Professionals: Implications for The Future". 150

INTRODUCTION

Donald E. Moore, Jr.
University of Illinois at Urbana-Champaign

For many years, continuing education has been viewed as a major vehicle for helping professionals maintain their competency in the face of accelerating social and technological change. Recently, however, there have been increasing demands that participation in continuing education activities be made mandatory for members of various professional groups. During the summer and fall of 1975, concerned individuals from the University of Illinois met on several occasions to discuss the problems and concerns they had about the accelerating movement to establish mandatory continuing education in several professional fields. From these deliberations grew the conference, "Mandatory Continuing Education: Prospects and Dilemmas for Professionals." On February 26th and 27th, 1976, approximately 200 respresentatives of all professional fields convened in Chicago to identify and discuss some of the issues surrounding mandatory continuing education and to examine across professional lines the various approaches that have been developed for implementing mandatory continuing education requirements.

The conference was divided into three major parts. In the first part, "The Professions and the Public: External Pressures for Mandatory Continuing Education", speakers addressed themselves to identifying the pressures generating demands for mandatory continuing education and examining the sources and strengths of those pressures. During the second part of the conference, "Professional Associations, Professional Schools, and Continuing Education", speakers described the ways in which professional associations and schools are attempting to meet the demands for mandatory continuing education. In the third part, "Impact of Mandatory Continuing Education on Institutions of Higher Education", speakers attempted to anlyze the relationship between mandatory continuing education and professional competency as well as examine the ability of institutions of higher education to provide increased amounts of continuing education programs. The three parts of the conference were connected by two series of workshops, each of which contained several sessions concerned with the approaches that have been developed to guarantee and maintain professional competency either through mandatory continuing education or some other means.

The articles collected in this volume of proceedings have been taken from manuscripts that conference speakers or workshop leaders provided. The order of their appearance here differs from that which occurred during the program. The presentations of workshop leaders have been arranged according to the three major topics (external pressures; professional groups, educational concerns).

The keynote address presented by John E. Corbally, Jr., President of the University of Illinois, set an excellent tone for the entire program. Dr. Corbally described briefly the phenomenon of social and technological change and the impact of this change on professional knowledge. He also described the emergence of mandatory continuing education for several professional groups, but cautioned that continuing education was being prescribed in some situations where it did not apply and was being used to perform functions that it was not designed to perform.

Representative R. Robert Geake from the Michigan House of Representatives, began the part of the conference dealing with external pressures with his paper, "Professional Services and Quality: Continuing Education as a Guarantee". Representative Geake reviewed some of the reasons mandatory continuing education was included as part of the requirements for licensure for physicians in Michigan. He also indicated, however, that there were some oversights in the legislation and some real problems with the notion that mandatory continuing education guarantees competency. Robert M. Derbyshire, M.D., Secretary-Treausrer of the New Mexico Medical Examining Board followed with his paper, "Mandatory Continuing Education and the State Regulatory Agency". He presented a historical overview of medical licensure and state regulatory agencies, emphasizing the conflict between the protection of the health and welfare of the public from incompetent and poorly educated practitioners and restricting admissions to the health professions. Dr. Derbyshire stated that two important elements in the present licensure system that should be reconsidered are the composition of licensing boards and the elimination of lifelong licensure. He contends that re-licensure linked with continuing education is no guarantee of continued competence, but it is a reasonable approach, and has resulted in the elimination of some incompetent physicians. Celia A. Maloney, Consumer Advocate, State of Illinois, conducted a workshop built around her paper "Licensing and the Consumer" which discussed the effect of licensing on quality control, prices of professional services, and entry into a profession. She indicated that a major dilemma exists on all boards between the restrictive character of licensing that limits entry into a professional field and necessary quality control. One solution that she proposed was to place consumer members on examining boards.

Usually, some kind of examining board is administratively connected with the state regulatory agency. In the case of engineers, the examining board administers a periodic examination to engineers which they must pass to be classified as professional engineers. In his paper, "Professional Engineer Requirements and the Role of Continuing Education", Jerry S. Dobrovolny describes the development of professional engineer licensing requirements and the various ways that engineers maintain their competency to remain classified a "professional engineer". Professor Dobrovolny discussed formal but voluntary continuing education as one of the ways by which engineers can prepare for these examinations.

In his paper, "Competency-based Relicensure", Robert K. Richards of the University of Michigan Medical School, reviews some of the problems associated with traditional concepts of licensure. Licensure has been focussed on initial entrance into a professional field and has been unlimited in time. In addition, it has been administered as a minor function by most state governments and professional associations have exercised considerable influence on examining boards and the credentialling process. Professor Richards describes the development of a movement toward relicensure, a movement that is connected with the knowledge explosion. Laws have been passed recently connecting relicensure with attendance at continuing education activities. Professor Richards argues that this kind of mandatory continuing education is not the solution; competency-based relicensure, he contends, is a better approach.

In his paper entitled "Greater Role for Universities in Setting Standards For The Professions," Philip E. Frandson of the University of California at Los Angeles, describes some of the issues surrounding the relicensure of professionals, and the responsibilities of the various constituencies involved. Professor Frandson argues for a greater role for the university, working in cooperation with other groups, in setting standards and in the deliberations about relicensure, as well as a central role in the planning, development, and presentation of all aspects of continuing education programs leading to relicensure.

C. Dale Greffe cautions that those rushing to implement mandatory continuing education requirements should stop to consider come of the problems of administering those requirements. In his paper, "Problems in The Administration of Mandatory Continuing Education Requirements," Professor Greffe, who is chairman of the Professional Engineer Examining Committee, outlines some of these problems such as identification of appropriate programs, verification of attendance, background preparation of registrant, and logistical arrangements.

Daniel C. Drucker, Dean of the College of Engineering at the University of Illinois at Urbana-Champaign, opened the section on "Professional Associations, Professional Schools, and Continuing Education" by presenting his paper "The Professional Schools, The World of Practice, and Continuing Education." Professor Drucker described the impact of changing pools of knowledge on engineering practice and the necessity of engineers to keep up through continuing education. Dean Drucker also described problems in participation in continuing education for engineers that are related to motivation and a career ladder that leads to management.

In his paper, "Professional Standards, Competency, and Continuing Education: Roles and Responsibilities of Professional Associations," William K. Selden describes roles and responsibilities that are at odds with traditional concepts of professional associations. Professor Selden contends that changes are occurring and that demands for accountability of the professions are being increasingly heard. He argues that because the concern for competency is wide-spread and because responsibilities overlap in so many cases in the delivery of professional services, control of continuing education can no longer be left to one professional association. Professor Selden describes some alternative roles for professional associations and concludes with a statement on behalf of shared responsibility for professional standards, competence, and continuing education.

William J. Greek, DDS, of the Illinois Dental Society, began his workshop by presenting his paper, "The Impact on Mandatory Continuing Education Requirements on Professional Associations." In this paper, Dr. Greek identifies some of the problems such as logistics, administration, and standards that arise when mandatory continuing study becomes a reality. Clarke W. Mangun, of the American Medical Association, describes the AMA Physician's Recognition Award in his paper, "An Alternative to Mandatory Continuing Education: The AMA Physician's Recognition Award." Dr. Mangun delineates the criteria for the several categories of credit within this voluntary system, provided some statistics related to the award, and discussed the prospects for voluntary vs. mandatory continuing education. Jeanne Burson, of Ohio State University, in her paper, "Accreditation of Continuing Education Programs for Professionals, describes the process of accreditation of continuing education by professional associations with particular emphasis on the PACE program of the American Society of Medical Technology. She also discusses the implications of mandatory continuing education on the accreditation process.

In her paper, "Impact of Mandatory Continuing Education on a Professional School," Ruth Heinemann, of the School of Associated Medical Sciences at the University of Illinois Medical Center, identifies the issues surrounding four aspects of the impact of mandatory continuing education on professional schools: availability of resources, strain on resources, impact on residential programs, and guaranteeing delivery. Diane Fisher and Marvin Weinstein, of the College of Pharmacy at the University of Illinois Medical Center, conducted a workshop entitled "Individualized Study as an Alternative to Mandatory Continuing Education" in which they presented their paper, "Three Decades of 'Continuing Competence' in Pharmacy: An Interpretive Review.' Ms. Fisher and Mr. Weinstein described the efforts of one profession to develop mechanisms to guarantee the continued competency of its members. Implied in this description is the important cooperative relationship between the professional school, the professional association, and the practitioner.

Morton W. Weir, Vice-Chancellor for Academic Affairs at the University of Illinois at Urbana-Champaign, opened the section of the conference dealing with mandatory continuing education and institutions of higher education with his paper entitled, "Mandatory Continuing Education and Professionals: The Responsibilities of Post-secondary Institutions." In his paper, Vice-Chancellor Weir describes how the pressure of technological change is making various professional groups select solutions that put great demands on the present post-secondary education system. While suggesting that faculty at these institutions should assume roles in helping find solutions to many of the questions raised by mandatory continuing education for professionals, he also issued a call for caution that institutions of higher education not assume too many responsibilities, especially those that belong elsewhere. Some of the roles that Vice-Chancellor Weir identified and described included analysis of the concept of mandatory continuing professional education; assessing educational needs and setting priorities; planning programs, evaluating of programs; and pioneering new developments.

Professor Cyril O. Houle of the University of Chicago, presented his paper entitled, "Evidence for the Effectiveness of Continuing Professional Education and the Impact of Mandatory Continuing Education," and indicated that the evidence for effectiveness was in measurement of performance. Translating performance into acceptance of innovations, Professor Houle stated that there is some evidence of positive correlation. What is needed, Professor Houle argues, is additional research directed toward more sophisticated measurement of performance.

Floyd C. Pennington, of the University of Michigan Medical School, began his workshop by reading excerpts of his paper, "Impact of Mandatory Continuing Education on the Program Development Process" in which he argues that the program development process can accommodate the intrusion of a few requirements. He describes four major impacts that include approval requirements, instructional design, public relations and marketing, and administration. John Thorpe, of the College of Dentistry of the University of Illinois Medical Center, conducted a workshop in which he presented his paper, "Systems for Delivering Continuing Education." Dr. Thorpe describes the basic components of delivery systems and important considerations in planning programs that use them. In her paper entitled "Impact of Mandatory Continuing Education on a Staff Development Program," Jacqueline Schudel of Carle Foundation Hospital in Urbana, Illinois, describes the staff development process in a hospital setting and explains how mandatory continuing education affects it. She also describes the efforts of one hospital, Carle Foundation Hospital, to integrate mandatory continuing education into its own promotion and rewards system. In his workshop, "Assessing Needs for Continuing Education," Robert P. Means, of the University of Illinois at Urbana-Champaign, reviewed procedures to consider in conducting educational needs assessment.

Alan B. Knox, Associate Vice-Chancellor for Academic Affairs at the University of Illinois at Urbana-Champaign, concluded the conference by identifying seven major issues regarding "mandatoryness" that confront persons who have concerns about continuing education activities for professionals and by describing the implications of these issues for the future of continuing professional education. These issues include the responsibility of each profession and the public for professional competence; necessity of persons with responsibility for continuing education to deal with policy issues; comparison of the advantages and disadvantages of mandatory requirements; the transitory nature of mandatory continuing education requirements; the role of professional standards in quality control and continuing education; importance of multiple sponsorship arrangements; and the importance of effective program development.

II

KEYNOTE ADDRESS

John E. Corbally, Jr.
President, University of Illinois

Change, The Professions, and Continuing Education

John E. Corbally
President
University of Illinois

It is a personal pleasure for me to have this opportunity to visit with this distinguished audience and to open this conference which we believe to be of great significance. As one who has almost daily opportunities to be reminded by individuals and groups from all walks of life of his need for radical continuing education measures to overcome a variety of personal and professional deficiencies, I should be listening rather than talking at this time. I have been reminded by students that I have forgotten what it is like to by young, by faculty members that I have forgotten what it is like to be in the classroom, by taxpayers that I have forgotten what it is like to pay taxes (at this time of the year as I struggle with my 1040 form I resent this reminder somewhat more than most), by business and/or labor leaders that I have forgotten what it is like to meet a payroll or to feed a family, and so on through many other groups. I suppose that I should take some satisfaction from the fact that most groups claim that I have forgotten rather than that I never knew anything in the first place.

In the words of the planning group for this conference, we are gathered here for these two days to identify the various social and professional pressures that are generating demands for mandatory continuing professional education and to examine the measures that governmental agencies, institutions of higher education, professional associations, and individual professionals are taking to address those pressures. Or, to go back a long ways to my days as a student in required psychology courses, we are here to study a stimulus-response system related to continuing professional education.

The planning group also suggested some objectives which I might attempt to meet in these opening remarks - objectives which contain the word, "briefly", several times. Without repeating those objectives so that only the committee and I will know the extent to which I succeed in meeting them, let me examine that stimulus-response system briefly and indicate what my examination leads me to conclude.

As we all know, stimuli can lead to responses which are related to each other either in an intelligent and logical manner or in a "knee-jerk" or salivation manner. It appears to me that some of our concern for continuing professional education relates to matters in which such education is not central at all. If we are to identify a set of pressures which we state generate demands for mandatory continuing professional education, we must be prepared to support our statement. Some of the pressures are real; some are not; and others are real, but relate only peripherally to continuing education. Let us examine this third category first so that we can, it is hoped, remove it from the agenda of the conference.

One pressure is a dollar pressure felt by institutions of higher education. The demographic fact is clear- the pool of typical students in higher education is shrinking as a percentage of the total population. In a society where any institutions survive on the basis of enrollment-driven funding formulas, this fact demands a response. Rather than to decide that we have too many institutions and to undergo the painful process of determining how to decrease the number of institutions, a solution is to redefine the enrollment pool. To the extent that this redefinition is conducted in response to a societal demand, it is appropriate; to the extent that it is conducted through the creation of an artificial societal demand, it is inappropriate. If institutions create an artificial demand to solve their own dollar problems, the solution will be short-lived and will find the institutions even more burdened with excess structure than is now the case. So we must beware of using a continuing education response to dollar and enrollment shortage stimuli.

Another pressure is what might be called the mystique drain facing the professions. Society has always been somewhat flexible in defining professions. We speak of the "world's oldest profession" to mean something in quite a different category than is, say, a brain surgeon. But in spite of this flexibility, there have always been a few "sacred callings" to which we generally have assigned the term "profession" - the ministry, the law, teaching, the health professions, the science professions, to name a few. These callings, however, today seem less and less sacred. Members of these professions strike, they engage in jurisdictional disputes, they make mistakes - their "feet of clay" seem almost more visible than their loftier features. If credentials and degrees helped create the sense of mystique surrounding a profession, can new levels of credentials help slow the loss of mystique? And, to be even less mystical, if a profession is becoming overpopulated can mid-career hurdles assist entry hurdles in holding down the numbers who are entitled to practice? As I listen to some discuss continuing professional education, I fear that the pressures of numbers and of loss of mystique are leading to a response which is couched in professional terms to mask a rather human problem. The continuing education response to mystique stimuli also seems inappropriate to me.

But surely, you will ask, there are real and direct pressures to which institutions need to respond through continuing professional education. Obviously there are. And, as a matter of fact, those pressures have been present for years. Today our opportunities are not based so much upon the novelty of the pressures but upon the circumstances which permit us to respond to them.

We are indeed in a time of change. Perhaps the greatest change of all is in our means of communicating about change, about new technology, and about new discoveries. Television, data phones, jet travel, and many other means of communication permit people to put the pieces together rapidly to create wholes and provide that the whole world in a sense can become a unified laboratory to test the results of change. As Donald Schon points out in his volume, Beyond the Stable State, it is pervasiveness of change perhaps even more than the rate of change which leads from the stable to the unstable state and which requires new kinds of responses as we attempt to control the process of transformation.

And if one adopts a definition of a profession in which an element of societal leadership is a major element, then those who lay claim to professional status must not only keep abreast of change or transformation or instability within their special area of expertise, but must also understand the societal changes within which they exercise their expertise. They must be prepared to lead in their expertise and to lead as society adjusts to change. A concentration upon change as a generator of technical obsolescence for a professional without at least equal concentration upon what might be called social obsolescence is to miss a crucial aspect of the needs of a professional person.

One example might illustrate this point. If we in our colleges of education assist our teachers to discover new ways in which technology can effectively involve the home as a teaching-learning center (e.g., a PLATO terminal in every living room), but fail to point out and to deal with the sociological fact of the disintegration of the family unit in our society, we are creating societal obsolescence while overcoming technological obsolescence. I happen to believe that in so doing we would be creating a serious net gain in professional obsolescence while pretending to do the opposite.

A fact of life today is the use of a term, "accountability", even though the meaning of that term is shrouded in mystery. In practice, that term often results in decision-making models in which the participant with the least expertise is granted the greatest credibility through the fact of his lack of expertise. If continuing professional education responds to a pressure named "accountability" through efforts to create greater and greater expertise on the part of the professional, does that program create more or less ability to be accountable for the professional? It is not too difficult to design programs which will present the professional practitioner with an ever-expanding array of professional facts. But will that program be a real response to a societal pressure for accountability? I doubt it, but I am fortunate today in that my task is related more to the raising of questions than to the providing of answers.

Let me mention one other pressure before I attempt to pull these remarks together into some sort of organized form. A task of our society - largely met through institutions of higher education - is to prepare specialized professionals to meet societal needs. I believe that higher education met and is meeting that task well. A new problem facing society is what might be called the "salvage problem". What do we do with a vacuum tube expert in the solid state age? What do we do with the humanities professor in the face of declining enrollments in his specialty? What do we do with the specialist in open pit mining as environmental forces reduce his opportunities to apply his expertise? The list of "what-do-we-do-with experts" is a long one and represents a human utilization problem of major proportions.

The educational problem here is not one of avoiding gaps in specialized knowledge within a specialty, but rather one of the redirection of human resources. If, as Schein has proposed in an excellent discussion under the heading, "What is a Profession?", a profession implies that the practitioner possesses a specialized body of knowledge and skills acquired during a prolonged period of education and training, the effect of a declining social demand for that specialized body of knowledge and skills could be that the practitioner must lose his professional status. The crucial question is the degree to which a less prolonged period of education and training than the initial period might redirect or create knowledge and skills for which demand is high. It is my personal bias that much of the current talk in higher education about the evils of the tenure system in a declining or steady-state environment reflects our failures in personnel administration and in continuing professional education rather than evils of the tenure system.

Let us review, then, the stimuli. Briefly, the legitimate stimuli appear to be pervasive technological change, equally pervasive and less well-defined societal change, and resulting problems of obsolescence of skills and knowledge and misdirection or misfit of skills and knowledge. These stimuli are joined by at least two others which while less directly related to continuing professional education are nonetheless real and have impact - enrollment declines in institutions of higher education (or, at least, fear of such declines) and declining societal reverence of and/or faith in the professions and professionals.

So what shall be the response? Let me state several things I believe should not be included. First, whatever the pressures or stimuli, higher education must not claim to be the sole chosen instrument to respond and to overcome. Too many of our current problems can be traced to our willingness to overrespond, to overstate our capacity to solve problems, to claim sole jurisdiction. We must not continue this altruistic, but unwise course of action. Second, we must not pretend that we have discovered something new. Many of you in this room have worked so long and so hard on behalf of continuing education - including continuing professional education - that you know it has been around a long time. But even you can fall into the trap of claiming novelty to attract attention and acclaim. Third, we must not design programs and establish courses and timetables and even determine certification terminology before we are clear about the stimuli to which we can and should respond. We have made too many curricular decisions under pressure in recent years and we have more clutter in our catalogs than we need. And finally, we must join in mandates with care and with caution. I can testify, now that my certificates have expired, that the forty-five quarter hours of work I took to convert my temporary teaching certificate to a permanent certificate (now an expired permanent certificate, to be sure) did neither me nor my students much good. Had I been required to work out a program which met my deficiencies, the results might have been different, but not only the hours but also the courses were mandated and it is statistics, not humans, which fit averaged needs.

All right - enough of what we should avoid. What should we do? The creation of answers to that question is the purpose of this conference and I do not want to leave you with time on your hands by meeting that purpose at the very outset of the sessions. But I will give a few of my feelings about the answers. First, we need to work with a number of groups including practitioner groups particularly to create agreement about the tasks to be performed. I do not mean the kind of working together that creates task forces and sub-task forces and which avoids action through analysis. I mean that as we generate programs we need to do so in cooperative ways so that everyone involved plays a part in the programs and has a stake in their success. We need to think small, if you will - to address some known problems and get started rather than to create a global design which results in global funding requirements. I am in favor of big thinking, but those who want to do something must also find a handle and move.

We need to recognize that the term "continuing education" is a redundancy and that the education of each one of us continues whether we want it to or not. Our task is to program a portion of one's continuing education so that portion will contribute to the ability of a professional person to serve his profession and his society. And let us be wary of those who confuse regulation and education. Continuing professional education will not create ethical human beings and will not guarantee against mistakes. Continuing professional education will not create all physicians in the image of Marcus Welby or all lawyers in the image of Perry Mason. But those who engage in the prolonged period of education and training through which professional knowledge and skills are attained and certified have an obligation to engage in programs designed to keep that knowledge and that skill updated and appropriately directed. Higher education is a major actor in the entry process and must be a major actor in the updating process. Of that there can be no question and no doubt. As you work together here to address these important questions, let no one imagine that our answer can be, "We're sorry, we're just not interested in that program".

III

THE PROFESSIONS AND THE PUBLIC: EXTERNAL PRESSURES FOR MANDATORY CONTINUING EDUCATION

PROFESSIONAL SERVICES AND QUALITY:

CONTINUING EDUCATION AS A GUARANTEE

R. Robert Geake, Ph.D.*
Michigan House of Representatives

It is indeed an honor for me to be before you today to speak to you on the subject of attempting to guarantee the quality of professional services through mandatory continuing education.

I would like to begin by outlining for you the forces that worked to shape Michigan's recently passed statute requiring Continuing Medical Education for physicians. I believe that an understanding of the Michigan experience with Continuing Medical Education will assist those of you who are in the planning stages for Mandatory Continuing Education in medicine as well as other disciplines in your own states. Even more valuable than an understanding of the forces that determined the final shape of this legislation is an examination of the oversights revealed by the Michigan experience. In many cases these oversights are still speculative because of the limited nature of the Michigan experience. I want to be forthright in relating these oversights in the hope that my report may prevent these mistakes from being repeated in other states.

When the Legislature convened in January, 1975, Michigan was facing a malpractice insurance "crisis." Many carriers of malpractice insurance had refused to accept any new members and one company that was a major insurer of Michigan physicians (Shelby Mutual) had announced its intentions not to renew its members' policies. Michigan was facing a situation where many of her physicians would be forced to quit practicing medicine. In this sense, the "crisis" was real, insofar as it required decisive and rapid action by the Michigan Legislature to assure that Michigan's physicians would be able to continue their practice. During the frantic months of searching for solutions to this crisis, two aspects of the problem assumed major importance:

1) premium costs were skyrocketing because of the rapidly increasing number of malpractice suits being brought against physicians, and
2) the skyrocketing cost of medical malpractice insurance was a barrier to physicians getting coverage.

The Michigan Legislature agonized over the medical malpractice insurance crisis. In all, 62 bills were introduced to alleviate the problem. Many of

---

* The speaker acknowledges his indebtedness to Dennis Paradis, M.P.H., of the Michigan House Research and Program Section for research and manuscript preparation and to Eugenia Carpenter, M.P.H., of the University of Michigan School of Public Health for review of the manuscript and helpful suggestions, and to Carol Hesselbacher, M.P.H., of the Michigan State Office of Health and Medical Affairs.

these bills were drafted to impact on either the prohibitively high cost of Medical Malpractice Insuracne or to restrict the number of malpractice suits being brought against physicians. After 8 months of intense legislative activity, 12 bills were signed into law by Governor Milliken. The 12 new statutes were designed to: 1) remove the physicians' problems of access to medical malpractice insurance at reasonable rates by creating a state Medical Malpractice Insurance Fund (later called the Brown-McNeely Fund); 2) reduce costly court cases by offering arbitration, 3) impose a 'statute of limitations' defining when a malpractice suit may be filed in relation to the termination of treatment or the discovery of evidence of malpractice, 4) expand the 'good samaritan' act, 5) restrict the sale or purchase of medical records, and 6) create or provide incentives for mechanisms to more closely monitor physician competence.

One of these 12 bills, H.B. 4799, which was introduced by Representative Raymond Hood and myself on March 26, 1975, amended Michigan's Medical Practice Act to require that as of 1977, medical doctors not be relicensed unless they show proof of having completed 75 hours of "continuing education courses . . . on subjects, related to the practice of medicine" within the 3 years preceding application for license renewal. This idea came from a study requested by Governor Milliken and executed by the state Insurance Commissioner. One of the 31 recommendations made in this study stated, "With the accelerating developments in the field of medicine, the Medical Practices Act (should) be amended to require 25 hours of education programs as a condition for license renewal each year. This requirement already exists in Michigan for those licensed by the Board of Osteopathic Examination and Registration."[1] Michigan's Osteopathic Practice Act had been amended in 1952 to include 8 hours of continuing medical education. On July 19, 1974, the Osteopathic Practice Act was further amended to require 25 hours of continuing medical education. Thus, 25 hours per year was the norm for continuing medical education in Michigan at the time of the medical malpractice insurance crisis.

H.B. 4799 was passed by the House less than a month after its introduction. It was followed closely by H.B. 4800, also introduced by Rep. Raymond Hood and myself, that proposed changes in the Osteopathic Practice Act so as to be consistent with the changes proposed for the Medical Practices Act. This included 75 hours of continuing medical education within a three year period before relicensure. In the Michigan Senate both bills came under new and different pressure. Membership in the American Osteopathic Association and eligibility for the American Medical Associations' Physician Recognition Award both require 150 hours of continuing medical education within 3 years. Both professional organizations lobbied the Senate to change the state continuing medical education requirements to be consistent with the requirements of their national organizations. Interestingly, both Associations were in favor of continuing medical education but did not want it mandated by statute. They were in favor of voluntary programs run through the state association or society. In the frenzy of passing much needed legislation to solve the medical malpractice insurance crisis, neither the Osteopathic Association nor the Medical Society were able to mount a campaign against making continuing medical education requirements so they were consistent with the requirements of the national association. Hence the standard became 50 hours a year and H.B. 4799 and 4800 were amended to require 150 hours of continuing medical education within a three year period preceding license renewal.

The bills were drafted to require 150 hours of continuing medical education within 3 years for 2 reasons: 1) It was consistent with the requirements of the national associations for Medicine and Osteopathy and, 2) it gave the physicians more latitude in completing the requirements. A physician would not be pressed each year to complete 50 hours of continuing medical education. Hence he could take different amounts of credits each year, depending on the physician's free time and interest in courses offered, as long as the credits totaled 150 in 3 years. At this point, the testimony of two state employees caused the bills to be amended. The secretaries of both the Medical Practice Board and the Osteopathic Practice Board protested that they would not be able to keep track of the continuing medical education credits for 15,000 physicians over a 3 year period without additional staff. Since it was impractical to appropriate additional state funds or to increase license fees to generate new funds, the bills were amended back to require 50 hours of continuing medical education each year. The intent was to simplify the necessary bookkeeping procedures so that no new staff would be required.

On June 13, Governor Milliken signed H.B. 4799 into law as Public Act 112 of 1975. This bill which required continuing education, passed through two committees, both chambers of the Legislature and was signed into law in less than 2 1/2 months. H.B. 4800 which established identical requirements for Osteopaths was signed 5 weeks later. Those of you who are familiar with the legislative process in any state will recognize that only a general atmosphere of crisis would precipitate legislation moving at this speed.

There is one further crucial element in understanding the Michigan experience with continuing education - the process of drafting administrative rules. For those of you unfamiliar with the legislative process, let me briefly explain that it is generally recognized as undesirable to specify exact standards for each concept within a statute. Therefore, the statute usually specifies the intent of the law and administrative rules are written to provide the exact standards. Administrative rules may clarify the intent of the statute but may not exceed it. Furthermore, administrative rules have the force of law. For example, Public Acts 112 and 174 of 1975 required only that Medical doctors and Osteopaths take 50 credits of continuing medical education each year. The administrative rules promulgated pursuant to these Acts specify standards such as how programs are to be accredited, who is responsible for accreditation, what standards are to be met before being accredited, etc. In the case in question, the administrative rules specified how those credits could be earned. The formula that was adopted roughly parallels the American Medical Association Physician Recognition Award criteria. The rules specify that credit must be earned as follows:

1) A minimum of 25 credits in continuing medical education programs accredited by the American Medical or Michigan State Medical Society

2) A maximum of 12 credits in non-accredited programs

3) A maximum of 16 credits by teaching medicine

4) A maximum of 15 credits by publishing books, papers, articles, etc.

5) A maximum of 12 credits in individual non-supervised continuing medical education activities, such as listening to tapes.

6) A maximum of 50 credits for course work if a physician is enrolled to pursue an advanced degree or to pursue the study of a specialty.

The rules that estabished this formula sharply upgraded the quality of the legislation. They have required that at least half of the continuing medical education requirements be fulfilled by attending accredited programs where the content and quality of the program are subject to review. At the same time, the physician is left free to fulfill the other half of his/her continuing medical education requirement in whatever manner is most convenient, accessible and interesting to the physician. This could include attending lectures, writing articles, teaching medicine, reading medical journals, and viewing prepared slide or videotape presentations, etc. Advanced electronic technology increasingly is being used to pass knowledge from the medical center to the field. For example, the Medical Information Service via Telephone, or MIST system allows physicians in rural Alabama toll free access to specialists at the University of Alabama in Birmingham.[2] A similar project in Missouri provides an Automated Physican Assistant. Sensors in a rural physicians office are connected via phone lines to a computer at the University of Missouri in Columbia.[3] A similar project called PLATO at the University of Illinois is just beginning to be used as a tool for continuing medical education.[4] As electronic communications technology expands there will be new and innovative ways to participate in continuing medical education programs. The structure of Michigan's continuing medical education laws will allow the physician to pursue the method best suited to his/her needs, while still retaining some control over the quality of programming.

As I have previously stated, Michigan's continuing education legislation was rushed through the legislative process in response to a crisis. Rapid and decisive action was called for and the Michigan Legislature responded. The result is that Michigan has a law requiring continuing medical education for physicians. But, let us now take a closer, more critical look at the problem. Let us assess the elements of the problem and measure how well this new legislation actually addresses them.

First, we must define the role of the state in licensing health professionals. In Michigan, as in many states, there is no written statute conferring this power on the state. Licensing is done as an extension of the state's police powers. The duty of the state to protect the "public health safety and welfare" provides the state authority to license. This police power is recognized in the 1889 United States Supreme Court case of Dent v. West Virginia. The U.S. Supreme Court rules: "The power of the state to provide for the general welfare of its people authorizes it to prescribe all such regulations, as in its judgment, will secure or tend to secure them against the consequences of ignorance and incapacity as well as of deception and fraud."[5] It should be noted that this decision referred only to licensure at the point when a professional entered the field since licensure weas generally granted for life at the time Dent v. West Virginia was handed down.

So we recognize that the state has the right to license in order to protect the public from, "The consequences of ignorance and incapacity as well as of deception and fraud." How prevalent are these elements in the medical profession today? Does the public really need protecting from physicians? Let us translate the terms of 'of ignorance and incapacity' to incompetence and the terms 'deception and fraud' to lack of good moral character. By using this terminology we can better relate the doctor of today to the Dent v. West Virginia decision. Based on known rates of drug addiction, alcoholism and mental illness and the prevalence of incompetence discovered by review of hospital case records, it is estimated that 5% of the nation's physicians are unfit to practice medicine.[6] This statistic does not discredit the medical profession. It is a normal attrition rate for professional persons in our society. What this statistic does say is that there are about 16,000 physicians in this country who are unfit to practice medicine. On an average, 72 medical licenses are revoked yearly in the United States.[7] This represents less than .5% of the problem. Thus, it would seem that the states are not fulfilling their duty to protect the public welfare.

To further complicate the problem, it has been suggested that much of the "bad" medicine is not produced by the 5% of unfit physicians, but rather by a larger percentage of physicians that practice sub-standard medicine. Dr. Avedis Donabedian, a professor at the University of Michigan School of Public Health stated, "There is much evidence to indicate that the quality of care available under many circumstances falls far below acceptable standards."[6] There are numerous studies that indicate Dr. Donabedian is correct in his assessment. Research has suggested that there are literally millions of unnecessary operations performed and billions of unnecessary prescriptions written each year. The result is thousands of unnecessary deaths.[6] If these statistics are any sort of indicator of the lack of competence and lack of professional conduct existing in the medical field, it is ludicrous to even suggest that states are protecting the public welfare by revoking an average of 72 licenses each year.

Having some grasp of the legal duty of the states and the magnitude of the problem, let us now see how continuing medical education may be expected to impact on the situation. Does continuing medical education reduce physician imcompetence? Are there better methods to assure physician competence? The answers to these questions must be carefully qualified.

First, continuing medical education is certainly a necessity for any physician to remain competent in light of a constantly growing body of medical knowledge. Unfortunately, a statutorily mandated continuing medical education by itself, does not assure or even significantly increase the competence of physicians. A physician who is dedicated to keeping up with the advances in the medical field will engage in continuing medical education with or without a statutory mandate. A physician who does not feel the necessity to keep up with the technological advances in the medical field will attend the courses, view the tapes, sign up for conferences, subscribe to medical journals, and do whatever is necessary to acquire 50 credits each year. Iy is quite possible to accumulate 50 continuing medical education credits yearly and learn practically nothing. In this regard, I am reminded of a favorite quip of my former psychology professor, the late Elton B. McNeil, who used to say, "A lecture may be defined as the process by which the notes of the professor go into the notes of the student, without going through the minds of either!"

The value of mandatory continuing education depends on the attitude of the individual professional. A professional that is motivated will learn without a mandatory continuing medical education statute. A professional that is not motivated will not learn despite the accumulation of continuing education credits. How many of us have attended required college classes, passed the tests, and retained virtually nothing in terms of content? Mandating participation in continuing medical education courses does not assure increased physician competence.

If continuing medical education does not assure increased physician competence, the state faces another legal problem. Since the state may license only to protect the public health, safety, and welfare, the state may only require that applicants meet conditions that affect the public health, safety and welfare. The Michigan Supreme Court has ruled that certain licensure requirements need not be observed becasue they do not affect the public health, safety and welfare. The most recent example is when the Michigan State Court of Appeals ruled that it was unconstitutional to restrict a cosmetologist's license to cut only women's hair. The court found that the restriction did not in any way protect the public health, welfare and safety and was not a legitimate condition of licensure.[8] Similarly, if continuing medical education does not assure increased physician competence, is it a valid condition of licensure? The Michigan Attorney General's office has considered this problem and has not been able to formulate an opinion. The reason for this ambivalence is that the potential value of continuing medical education in assuring the public's health, welfare and safety has not yet been proven.

Certainly, continuing medical education holds the possibility of upgrading physician competence. It is this possibility that makes continuing medical education an appropriate condition of licensure. The question remains: how do you draft legislation that raises that probability to the level of certainty? The answer to this question lies in considering continuing medical education not from a medical perspective, but rather from an educational perspective.

What we are attempting to do through continuing medical education is to modify the behavior of physicians. Ideally, the physician will utilize the information available through continuing medical education to practice better medicine. From an educational standpoint we should understand, 1) what physician behaviors we wish to modify, 2) what methods are best suited to modify these behaviors and 3) how we can evaluate a change in behaviors. In mandating continuing medical education, we have not defined what behaviors we wish to modify; yet we assume, without measurement, that these behaviors, which we have not identified, will be modified in the direction we wish. Assuming all of the possible results (behaviors to be modified x outcomes of random educational methods), it would indeed be surprising if mandatory continuing medical education achieved its desired objectives.

In Michigan, the State-wide Health Planning Advisory Council formed a task force to investigate health personnel licensure and certification. The task force identified 9 areas that it considered crucial elements of professional competence:

1) current technical knowledge
2) current technical skills
3) diagnostic abilities
4) interpersonal skills
5) ability to recognize one's limitations
6) record keeping
7) appropriate use of other health professionals
8) patient participation in treatment alternatives
9) professional integrity

The task force noted that these elements had differing importance for different specialities (e.g. technical skills for a surgeon as opposed to interpersonal skills for a family practitioner or diagnostic abilities for an internist) and that there are different methods with which to measure a physicians' level of achievement in each of these areas.[9] Using such a list of behaviors, we can determine where physicians exhibit the greatest need for improvement and concentrate our continuing medical education efforts in that area. Such assessment of a professional's individual educational needs is the key to assuring that continuing education results in desired upgrading of skills and knowledge and not merely in academic exercises.

In Michigan we made the mistake of not fully considering the difficulties in establishing a quality continuing medical education program. The Michigan legislation required proof of continuing medical education for relicensure in 1977, meaning that physicians must accumulate 50 credits of continuing medical education this year. At least half of these credits must be from accredited courses. At the time Michigan's continuing medical education legislation passed there was only one place in the state, the University of Michigan Medical School, that could provide accredited courses. The American Medical Association and the Michigan State Medical Society have been working diligently to get other medical schools and hospitals accredited so that an adequate number of accredited programs exist to fill the needs of their members. Accreditation is granted on the ability of a facility to provide a high quality educational program. The short time frame makes an assessment of physician needs very difficult although both a needs assessment and an assessment of behavior modification are requirements for accreditation.[10] The logistics of organizing a high quality continuing medical education program, including the administrative structure, budget, teaching staff, curriculum, adequate facilities, educational methods and evaluation methods, of getting that program accredited and implementing that program in time for physicians to earn credit before 1977 are truly staggering. I salute the Michigan State Medical Society for their efforts. The Osteopaths were in a somewhat better position by virtue of having had mandatory continuing medical education requirements in the past. I would caution those of you considering mandatory continuing medical education legislation to leave yourselves adequate lead-in time to build a quality program.

Another mistake of the Michigan experience was not giving adequate consideration to the appropriate interval for relicensure. If the purpose of licensure is to safeguard the public health, safety and welfare by assuring physician competence, then it is unnecessary to relicense any more frequently than it is possible for a physicians' knowledge and skills to become outdated. I have recounted earlier how the Michigan legislation reverted from a three-year cycle to a yearly cycle in order to simplify bookkkeeping. In terms of changing medical technology, the minimum relicensure interval would be three years and the maximum interval eight years. At its present rate of growth, it has been estimated that medical information doubles every 8 years and has a half-life of 5 years.[11] On this basis I would suggest that, assuming a physician is competent at the point of initial licensure, relicensure periods of 4 to 6 years would be adequate. This type of licensing interval not only would protect the public welfare, but would also lessen the demands on physicians and the demands on the state budget to provide manpower for licensing procedures. I would urge states developing licensing legislation to consider the relicensure interval for all professionals carefully.

I spoke earlier of alternate methods of assuring physician competence. Other methods exist, but unlike continuing medical education which is a process to achieve increased competence, the alternate methods are actually checks on the level of competence. The most common alternate methods are, 1) peer review, 2) practice audits, and 3) re-examination. The peer review mechanism has the advantage of having physicians being evaluated by those best equipped to evaluate them - other physicians. It also has the obvious drawback of not being an objective standard. A sense of fraternity develops within a profession that impairs an objective assessment of one's peers. Michigan presently has a 'sick doctor act' which requires physicians to report any of their peers that are unfit to practice medicine.[12] The unfit physician is then put on probation until his/her problem is under control. This experience has proven that physicians, like any other professionals, will protect their peers from disciplinary actions.

The practice audit mechanism has the advantage of monitoring a physician's actual work, rather than his ability to pass some arbitrary standard such as a test or specified number of credits. It would seem to be the most accurate measure of a physician's competence. It is actually a specific structured form of peer review where the peers are onsight. It has many of the same drawbacks as the peer review mechanism and the additional drawback of being extremely costly.

Re-examination has the advantage of being both an objective and economical mechanism to measure physician competence. It is a familiar mechanism to physicians since passage of a state examination or its equivalent is necessary for initial licensure. However, to be a useful tool in gauging physician competence, some statisticians would argue that a percentage of physicians must fail the examination. If all physicians pass the examination, the examination would appear to be too simple. If all physicians below a certain score or the physicians scoring in the bottom 5% of the distribution of scores are designated as "failing" the examination, have we located the incompetent or unfit physicians? Low examination scores alone do not necessarily prove incompetence. It may be unfair to deny relicensure to a physician solely on his inability to correctly answer examination questions. The standard is too arbitrary. The State of New Mexico, which as completed a mandatory continuing medical education cycle of 120 hours over a 3-year period, has encountered a similar problem. Of the physicians practicing in New Mexico, 8% failed to be relicensed due to failure fulfill continuing medical education requirements. The state lost 112 practicing physicians because of their failure to meet continuing medical education requirements. There is no proof that these physicians were incompetent. They were not relicensed because they failed to meet an arbitrary standard of academic credits - not because they failed to meet a standard of competence.[13] This is one very real danger of setting up arbitrary standards of which states should be aware.

So far I have spoken principally of the problems and mistakes encountered in Michigan's experience with continuing medical education legislation. Let me close my address on a positive note by suggesting how continuing medical education can be constructively used to upgrade physician competency. I have discussed the merits and limitations of different methods of assuring physician competence. The key to an effective method of assuring physician competence is to combine these different mechanisms so as to utilize the strong points of each. In 1947 the American Academy of General Practice led the field by requiring its members complete a specified number of continuing medical education credits to annually maintain membership. In 1976 the American Board of Family Practice (a product of the evolution of the American Academy of General Practice) will undergo its first recertification procedure. Included in this procedure is, 1) mandatory continuing medical education, 2) a practice audit and, 3) a half-day examination. Just as in 1947, I believe that the American Board of Family Practice is once again leading the way.

Recall the elements of an educational program which I delineated earlier: 1) defining the behaviors to be modified, 2) defining the methods to achieve this behavior modification and 3) evaluating the success of the attempted behavior modification. As I pointed out previously, continuing education is only the second element - the process by which behavior is modified. Before requiring the education process, let us require an examination to define the educational needs of the individual professional. The initial examination results would not determine whether a professional will be relicensed but would be used to indicate the areas where his knowledge and skills are weakest. The examination mechanism can be utilized to identify the specific educational needs of the individual professional - the behaviors to be modified. With that knowledge, let us require continuing education in the specific area of educational need. This is the way to upgrade competence. Without this measure of his/her weak areas, which the professional is generally unaware of, the professional will tend to participate in continuing education classes that either are convenient or are personally interesting rather than in those classes where his/her knowledge or skills are most in need of improvement.

Having assessed the professional's educational needs by examination and provided education to upgrade the areas where knowledge or skills are sub-standard, we can now assess the effectiveness of the process by means of peer review and practice audits. These mechanisms allow a physician, for example, to be evaluated by his peers in the actual practice of medicine. Those best qualified would be performing an evaluation at the best possible time. In this case negative evaluations would not be used for disciplinary purposes, but should be used to help the professional upgrade his/her knowledge and skills. Peer review and practice audits done periodically will provide before and after data from which an assessment of behavior modification can be made. Furthermore, the information gained by peer review and practice audits can be utilized in the needs assessment process. So the evaluation process feeds back into the needs assessment process and the cycle begins again. Through this process we can actually surpass the concept of continuing professional education and achieve Continuous Professional Education.

I hope that the observation and perceptions that I have drawn from the Michigan experience will be helpful to those of you contemplating licensing legislation. Michigan is presently in the process of recodifying all of its public health legislation. This has been a 15-month project called the Public Health Statute Revision Project, or PHSRP. One of the tasks PHSRP has undertaken is to develop a comprehensive legislative stance on the licensure of health professionals. PHSRP and the Task Force on Health Presonnel, Licensure and Certification have now formulated their recommendations and the result has been most interesting. The PHSRP code will provide that within six years of the passage of the code, each licensing board would establish a system for relicensing, based on continuing competency. Furthermore, during the six-year interim, the individual licensing boards would be empowered to initiate pilot programs to assess competency and investigate alternate approaches to periodic relicensure. This will provide a "practice" period for Michigan to gain experience with different forms of relicensure and competency assessment. I think this is a beneficial approach for any state to pursue. These proposals are linked with Task Force recommendations that relicensing be based on continuing competence, and that each licensing board establish an advisory committee which includes educators. This is a strong statement regarding both the value of continuing medical education and the necessity of including continuing medical education within the very framework of the profession. I am confident that Michigan will act on these recommendations over the next few years. The result will be more competent health care providers.

References

1. Dively, Michael A. "Medical Malpractice in Michigan - A Report to Governor William G. Milliken." Lansing, Mich. Feb. 18, 1975.

2. "Fostering the Growing Need to Learn" - Monographs and Annotated Bibliography on Continuing Education and Health Manpower. 1974.

3. Miller, James G. "Computer Based and Computer Planned Continuing Medical Education for the Future." *J. Am. Med. Assoc.*, 1968 (Vol. 206, No. 3) pp. 621-624.

4. Bitzer, Donald and Skapardas, D. "The Design of an Economical Large Scale Computer Based Education System." CERL Report X-5, Univ. of Illinois Computer Based Education Research Laboratory. Urbana, Ill: 1972.

5. Dent v. West Virginia. 129 U.S. 114, 121-22, 9 S. CT. 231 (1889)

6. Rensberger, Boyce, "Unfit Doctors Create Worry in Profession." *New York Times*, Jan. 26, 1976.

7. Rensberger, Boyce. "Few Doctors Ever Report Colleagues Incompetence." *New York Times*, Jan. 29, 1976.

8. People vs. McDonald. Mich. Ct. of Appeals #23769. (Jan. 27, 1976)

9. "Preliminary Recommendations of the State Health Planning Advisory Council Task Force on Health Personnel Licensure and Certification." Lansing, Mich: Office of Health and Medical Affairs. January, 1976. (Unpublished Draft - not for distribution).

10. "Accreditation Manual for Continuing Medical Education Activities in Michigan." East Lansing: Michigan State Medical Society. Undated.

11. Unsigned Editorial. *J. Am. Med. Assoc.*, 1971 (Vol. 217, No. 5) p. 688.

12. Michigan Medical Practices Act. P.A. 185 of 1973. M.C.L. 338.1812 [M.S.A. 14.542(12)]

13. Derbyshire, Robert. "Relicensure 1975." New Mexico Board of Medical Examiners.

RELICENSURE, MANDATORY CONTINUING EDUCATION AND THE STATE REGULATORY AGENCY

Robert C. Derbyshire, M. D.
Secretary-Treasurer
New Mexico Medical Examining Board

For many years all examining and licensing laws, including those governing the professions, have periodically come under fire from a variety of sources. State legislatures have repeatedly expressed concern over licensing procedures which, they claim, all too often act as a detriment to the public welfare. One of the strongest indictments of the entire licensing process came from Milton Friedman[1] when he said, "Yet the conclusions I shall reach are that liberal principles do not justify licensure even in medicine and that in practice the results of state licensure in medicine have been undesirable." One of his most damning allegations is that the number of physicians admitted to practice is often limited by licensure.

Many state licensure laws of all kinds contain pious statements to the effect that they were passed in the interest of the health and welfare of the public. Nevertheless no such laws have been passed as a result of public demand for them. Invariably legislation has originated within the professions or trades themselves. This understandably gives rise to the dark suspicion that the laws were devised to serve the interests of the sponsors rather than those of the public.

Despite the validity of many criticisms of licensing laws, is the answer to abolish them or to reform them? To provide an answer to this question let us briefly review the history of professional licensure in the United States. In the early days of the colonies the authorities made only occasional ineffectual attempts to regulate the practice of medicine. According to Shryock[2] no regulation was really attempted before the 1960's but this was not because educated men were indifferent to the problem. In fact, leaders in Massachusetts repeatedly expressed concern over the situation. For example, Dr. William Douglas of Boston, in 1753, said, "Frequently there is more danger from the physician than from the distemper."

In 1780 a group of practitioners became concerned and referred to "that unhappy slaughter which is daily made amongst our fellow citizens by the barbarous bands of medicasters. That some laymen were also concerned is attested to by the following statement of William Smith in 1757: "Few physicians among us are eminent for their skill. Quacks abound like locusts in Egypt. This is less to be wondered at as the profession is under no kind of regulation. Any man at his pleasure sets up for Physician, Apothecary, and Chirugen."

During the ensuing years regulation of medicine gradually evolved.[3] In the beginning the preceptors licensed their students to practice. Later the medical societies assumed the power of licensure; the process was then partially taken over by the medical schools, such as they were. In every case the system failed because abuses in each field caused lowering of standards. This led to the present method of licensure by boards which are agents of state governments. This system has been in effect for over 75 years and has generally been successful despite inconsistencies in the laws, the lack of uniformity in standards, and the capriciousness of some licensing boards.

From the above historical sketch one might conclude that one can easily delineate the functions of the licensing boards, well defined arms of government. Their sole function should be to protect the public against incompetent and poorly educated practitioners both by examining their qualifications before licensure and by removing them from practice should their ignorance or ethical and moral delinquencies cause danger to their patients. That members of the public are so stupid that they need the paternalistic hand of government to guide them in seeking medical care is debatable. However, licensure should assure the people that physicians possess at least minimal competence. One must ask, however, are the licensing bodies dedicated solely to the protection of the public health and welfare? In this respect the records of the boards have been spotty in that they have succumbed to political pressure from the members of the profession and have often limited the entry of physicians into practice. One board even went so far as to establish an annual quota system and based the failure rate on the examinations upon this rather than upon any demonstrated knowledge of the applicants. Fortunately, due mainly to public pressure, this policy is no longer widespread; but one can still find occasional instances of restrictive policies.

Licensing boards, presumably dedicated to the welfare of the public, are creatures of the legislatures which created them. Moreover, the legislators, in their great wisdom, can amend the licensing laws at will, which they frequently do either to show their zeal for protecting the public or for less lofty political motives. The legislatures even have the power to abolish licensing boards. This has happened in medicine only once to date. In 1838 the legislature of Maryland[4], apparently disgusted with the licensing process of physicians, repudiated the medical practice law and passed an act making it lawful for "each and every person being a citizen of this state to charge and receive compensation for their services and medicine the same as physicians." From that date until 1892 Maryland was without a licensing board. Whether or not the health of the citizens suffered greatly during this period, I am unable to say. But it is obvious that licensing boards are responsible to the legislatures.

The boards are also responsible to the executive branch of the government in that in almost all states the members are appointed by the government and serve at his pleasure. The direct accountability of boards applies mainly to the states which have so-called free-standing boards. In other states there are various agencies interposed between the boards and the executive. For example, seven states and the District of Columbia have departments of registration and licensure which have direct authority over the boards; in three states they are under the board of health, while in one the board is under the department of education. This leaves 40 states with free-standing boards. There is an increasing tendency of legislatures to place boards under all inclusive departments of licensure presumably in the interest of economy and greater efficiency and also to correct real or imagined abuses of power by the boards. The professional societies usually oppose the abolition of free-standing boards because they fear loss of autonomy.

It is evident from the above that if anyone proposes reform of licensing laws he must run the gauntlet of many agencies before he can expect favorable consideration by the legislature, no matter how meritorious his proposal.

Important in the relationship of licensing boards to regulatory agencies is their composition. Until recently membership on boards was entirely confined to members of the profession they were designed to regulate. Advocates of this system claimed that it was wth only method of regulation, especially as applied to medicine, as the problems of licensing are so complex and technical that only the members of the profession can understand them. Not so! claim the critics. Well educated laymen, even though they do not understand all of the intricacies of the practice of medicine and the educational background upon which it rests, can have important functions in helping to formulate sound policies. Futhermore, these are public boards and the public should be represented on them. Those who oppose sole regulation of the profession by its members have compared the process to the fox guarding the chicken coop. Even more unkind was a columnist who recently likened the system to Dracula guarding the blood bank.

For many years members of the medical profession were adamant in their stand that only physicians should serve on licensing boards. They considered any doctor who advocated the inclusion of representatives of the public on boards as heretical, beyond the pale, and directed their full scorn against him. (I have been the target of such scorn.) However, in recent years, due partly to professional enlightment and partly to the increasing awareness of the demand for public accountability, the members of the boards, if not the medical societies are beginning to look with grudging favor upon the inclusion of non-medical people on licensing boards. California led the way when, in 1968, its legislature amended the medical practice act to require the appointment of one representative of the public to the board. Surprisingly, from talking to members of the board later, I learned that they had warmly accepted the public member and their original uneasiness had been allayed. Today eight states - California, Maine, Michigan, Minnesota, New Jersey, Ohio, South Dakota, and Washington - have a total of 10 non-physicians in positions of judging the performance of physicians. Interesting is the fact that in almost all instances the medical associations opposed such amendments.

Still unsettled is the question of the suitable number of representatives of the public who should be included. Cohen[5], in reviewing proposals for restructuring board composition, refers to the addition of one or two public members as only a token change. With this I disagree. The opposite extreme has been reached in Minnesota whose licensing board now includes four public members. Perhaps the ultimate protest against licensing boards was that of Governor Brown of California who recommended that no physicians at all be included on the board. To date the legislature has not followed this suggestion.

No matter how honorable and conscientious professional board members may be, the fact remains that they are essentially political creatures, frequently of the medical society which recommended them for appointment. Therefore, in decision making they are bound to be influenced by their profession and not always with the highest motives. Physicians, in the past, have tended to look upon non-medical board members as spies who would report real or imagined machinations of the boards to the governor or possibly to the public. Assuming that the board members have nothing to hide, this is a ridiculous viewpoint. If it is necessary to have a public representative on a board as a watch dog, so be it. Furthermore, there is no justification for restriction of numbers of physicians admitted to practice, provided they are qualified. Their distribution can best be governed by the laws of the marketplace.

And now, having painted a rather unlovely picture of professional licensure, I shall discuss some of the improvements which are gradually being effected. Prior to 1969, once a physician had received his license, it was his for life, provided he committed no offenses which would warrant revocation, a rare occurrence indeed. Year after year, merely by paying his annual registration fee he was able to maintain his license in good standing regardless of how ignorant he had become of the modern practice of medicine. In spite of extended absences from practice, or even the onset of senescence, his license remained valid. A beginning change occurred in 1969 when the Kansas legislature passed a law requiring continuing education for relicensure. However, there was a curious proviso in the law to the effect that the requirement could not be implemented without the approval of the majority of the members of the Board of the Healing Arts. To date no such approval has been granted.

Later New Mexico led the way towards the abolishment of lifelong licensure when, in 1971, the legislature passed a law which granted authority to the licensing board to establish criteria for relicensure connected with participation in programs of continuing education. Sponsored by the New Mexico Medical Society, and permissive in nature, the law was promptly implemented by the board which published necessary rules and regulations. The law had been opposed by a vociferous minority of the members of the medical society whose objections were based upon their hatred of compulsion, their fear of the bureaucrats in the state capitol, and dire predictions that the law would seriously disrupt the practice of medicine throughout the state by causing an acute shortage of medical manpower. Three years later the hue and cry had finally abated after the opponents had unsuccesfully challenged the law on three different occasions.

From the inception of the plan to require relicensure linked with continuing education, the officials of the New Mexico Medical Society, of the School of Medicine of the University of New Mexico and the members of the Board of Medical Examiners agreed that cooperation among these institutions would be essential. Moreover, they all believed that, although the requirements should not be too harsh, they must insist upon programs of quality. The rules, as finally formulated, reflect this attitude and also permit considerable flexibility thus heeding the contention of many people that nothing could be accomplished by confining the program to lectures by dull speakers to apathetic captive audiences. The medical school has been most helpful in devising individual programs to meet the needs of physicians on request. One plan in essence encourages physicians from the outlying regions to join in the work of the school for varying periods of time. Furthermore, the medical school is encouraging senior residents to substitute for physicians in outlying communities while they are absent to engage in continuing education. This arrangement, while not yet in wide operation should prove of mutual benefit; one possible advantage is the opportunity it can afford the residents to gain experience in family practice.

The regulations of the board are simple, requiring 120 hours of continuing education every three years. However, the types of hours are carefully defined to insure quality. The end of the first reporting period was December 31, 1974. As expected, a number of physicians did not meet the requirements. Out of a total of some 2500 registrants, the board has suspended the licenses of 127. Of these, 90 were residing outside of the state and were unable or unwilling to comply. Of the 37 residents of New Mexico whose licenses were inactivated, 14 retired or withdrew voluntarily. Important is the fact that the majority were over 65 years of age and several were 75 or older. The loudest protests came from the octogenarians. Obviously decimation of medical manpower in New Mexico has not resulted from the law as the prophets of doom had predicted.

A valuable byproduct of the relicensure law has been the elimination of a certain number of superannuated physicians who, valuable as they might have been in the past, became incompetent through loss of knowledge and skills due to the inevitable aging process.

Objections to relicensure linked to continuing education have arisen from several sources, particularly from the educators. They contemptuously refer to the system as the meaningless acquisition of "Brownie Points" and say, "Can you produce any studies to prove that continuing education changes the practice habits of physicians or improves patient care?" To which my rejoinder must be based mainly upon anecdotal evidence rather than upon the results of sound scientific studies which do not exist. I point to the burgeoning of continuing education programs and the ever increasing interest in them which, of course, is not entirely due to the existence of the law. Notable is the fact that physicians who have never been seen in a scientific meeting before have become regular attendants. The Canadian Medical Association, which has gone on record as favoring compulsory continuing education, counters the argument by stating that one cannot "measure the unmeasurable."

Meanwhile the movement for relicensure connected with continuing education is spreading throughout the country as more legislatures register their disapproval of lifelong licensure. At present there are ten states - California, Illinois, Kansas, Kentucky, Michigan, New Mexico, Ohio, Virginia, Washington, and Wisconsin - which have such laws in various states of implementation. In addition, bills have been prepared for introduction into the legislatures of New York, Utah, and Iowa and at least three other states are seriously considering them. While not yet widespread in Canada, one province, Ontario, has such a legal requirement and the authorities of Alberta are considering such a law.

What problems are the licensing boards encountering in the implementation of the relicensure laws? While in most states these laws are so new that details of implementation have not yet been spelled out, a pattern of real or imagined difficulties is emerging. The licensing officials are claiming that the legislatures have not appropriated enough money for operation of the programs. I point to one state board in particular which has thrown up its collective hands at attempts to implement its law, complaining that the legislature has failed to make any appropriation whatever. In their desperation the board members have merely requested that the licensees, as they obtain the Physician's Recognition Award of the AMA report this to the board. From experience, I can definitely state that implementation of the laws does not require staggering sums of money.

Other licensing boards complain that the process of evaluation of continuing education is too tedious and time consuming. Unfortunately this is true and so far efforts at teaching the computer to evaluate reports of continuing education have been unsuccessful; they must be evaluated individually. But a well trained person, not necessarily a physician can evaluate about 100 applications a day. I have no doubt that these objections will soon be met, although I do not know how to overcome the penuriousness of the legislatures.

Assuming that lifelong licensure is not desirable, what are some alternatives to the legal requirement of continuing education, certainly a mild approach? First there is periodic reexamination for relicensure as advocated by Senator Kennedy as a federal requirement. This I reject out of hand. In the first place it would be a logistical and bureaucratic nightmare. In the second place, even if the vast majority of physicians passed, as one would hope, it could cause severe disruption of medical practice throughout the entire country. Moreover there is the question as to who would select the examiners and in what fields would physicians have to be examined?

Another suggestion, long advocated by the American Society of Internal Medicine, is a system of evaluation based upon observation of physician performance in caring for patients. Admirable as this concept may be, to date it is not yet on a practical basis especially as applied to relicensure. Then there is the plan for recertification already adopted by the American Board of Family Practice. This is based jointly upon reexamination, office audits and continuing education. Although this has no legal standing, I believe that the majority of licensing boards will accept successful completion of these requirements for relicensure.

Another suggestion is that the Professional Standards Review Organizations (PSRO) could provide data upon which relicensure could be based. Concerning this I have reservations as the PSRO concept, since it's inception, has been the monitoring of cost control rather than quality control.

The American Specialty Boards will no doubt eventually play an important part in relicensure. Although they have no legal standing, all 22 boards have gone on record as favoring the recertification of specialists. Three of them have immediate plans for recertification. As specialty board recertification will no doubt be based upon valuable education experiences, it will probably be acceptable for relicensure.

Obviously a trend is rapidly developing in this country to do away with lifelong licensure by requiring relicensure linked to continuing education. Although this provides no guarantee of continued competence, it is a reasonable approach which has been tested on a small scale and has been found to eliminate a significant number of incompetent physicians from practice. An editorial in the Medical Post of Canada neatly summed up the situation as follows: "So far in Canada our continuing education sessions have been attended by the converted. But the time has come when we will have to take the New Mexico approach and get the unconverted into the church, even if they come kicking and screaming." As in Canada, the time for action in the United States has arrived.

References

1. Friedman, M., Capitalism and Freedom, Chicago, University of Chicago Press, 1962, pp. 137-160.

2. Shryock, R. H., Medical Licensing in America, 1650-1965, Baltimore, The Johns Hopkins Press, 1966, pp. 4-5.

3. Derbyshire, R. C., Medical Licensure and Discipline in the United States. Baltimore, The Johns Hopkins Press. 1962, pp. 5-7.

4. Gundry, L. P.: History of the Board of Medical Examiners of Maryland. Maryland Med. J. 7: 5-6. 1958.

5. Cohen, H. S.: Professional Licensure, Organizational Behavior, and the Public Interest. Milbank Memorial Fund Quarterly Health and Society 51: 82. 1973.

LICENSING AND THE CONSUMER

Celia A. Maloney
Consumer Advocate, State of Illinois*

Licensing may protect the public by having state authorities operate a "quality control" program or it may raise prices to the consumer by having state authorities sanction a "restricted entry" program.

RESTRICTED ENTRY ARGUMENT

The restricted entry argument is best explained by using the example of a group of professionals or firms seeking to raise prices by limiting output. If they were to arrange a price and output-fixing cartel and make it difficult for cartel members to cheat on the agreement, prices would begin to rise. However, firms or professionals in other industries or occupations would be drawn into the business once the rewards were greater than the cost of buying new plants and equipment (for firms) or of becoming trained in the profession (for individuals). The new entrants would cause an increase in output which would eventually lower prices and negate the cartel's efforts. In order to maintain non-competitive or monopolistic prices, the cartel must restrict entry into the industry or occupation.

One method of restricting entry is to create a governmentally-sanctioned "licensing" scheme. Then the state agency or board would be used to restrict entry by limiting the quantity of licensed firms in the industry or licensed individuals in the occupation. The professionals would receive additional income from the non-competitive prices they charge and new entrants would be limited through the licensing process. Consumers pay higher prices for the occupations output as a result of government's intervention in the marketplace in this manner.

However, this restricted entry argument assumes that consumers would not suffer in a situation where the state did not intervene and there was unrestricted entry. This leads to the quality control argument for licensing.

QUALITY CONTROL ARGUMENT

The quality control argument rests on any one of three premises. The first is that consumers could suffer irreparable harm if unlicensed individuals were allowed to practice certain professions. For example, a patient may die at the hands of an incompetent "doctor" with no opportunity to try again at another hospital. This premise simply states that some markets (such as that for operations) do not offer the same opportunity for consumers to shop around and select by trial-and-error that other markets offer (such as that for toothpaste).

---

*Licensing legislation for both occupations and professions are administered by a single agency in Illinois, the Department of Registration and Education.

The second premise states that even if consumers could shop by trial and error, they are, in most cases, incapable of evaluating the technical skills of those they buy services from. This premise simply states that the market is extremely complex and consumers will have difficulty making sound judgements.

In both of the above cases, the state, by establishing an occupational licensing program, solves many of the problems posed by incompetent and unethical practitioners. The state, it is argued, runs a "quality control" program which in the end protects consumers from shoddy service and wasted expenditures.

THE EVIDENCE

Economists and others have long been attempting to resolve the occupational controversy by looking at available data. Several findings which support the restricted entry argument are presented here.

A 1974 Federal Trade Commission study showed that licensure of television repairmen in Louisiana resulted in 20% higher TV repair prices there than in California where repairmen were not licensed but simply "registered". Restricted entry into the occupation thus costs consumers via higher prices.

A 1965 study showed that the "pass rate" of applicants to the professions of dentistry and law in a state was inversely related to the incomes of dentists and lawyers in that state. The theory that restricted entry would increase incomes (and certainly consumer prices) is borne out since the effect of eliminating new entrants by failing them results in enhanced incomes. This study does rest on the assumption that the dentists and the lawyers had some control over the exams; since some 75% of the licensing boards in the country are composed exclusively of members of the profession this is a good assumption.

The conclusion of this 1965 study, in other words, is that states with low pass rates for applying dentists and applying lawyers have higher average dentist and lawyer incomes and, consequently, higher dentist and lawyer fees and prices.

A more sophisticated 1974 study also analyzes the pass rates on exams for licenses to professional income and to "excess demand". The researcher theorized that aspiring professionals would generally attempt to take exams in states with a greater demand for their services than other states. The number of new applicants (after adjustment) was used as a measure of excess demand. Using 1940 and 1950 data, he found that a 10% increase in excess demand would generate a fall in the pass rate of between 10% and 5% for half of the 18 occupations he studies. So professions in states with rapidly increasing demand for their services tended to use the pass rate mechanism to fail potential entrants into the profession and prolong the period during which they receive high income due to increasing demand by restricting entry.

Another 1974 study examined the pass rate on occupational licensing exams in Delaware, Connecticut and Rhode Island. The implicit question by these researchers was: Would plumbers on the Plumbers Examining Board fail more applicants when construction unemployment was high and plumbers already licensed in the state were unemployed or underemployed? In addition they studied barbers, electricians, and embalmers. In 10 of 12 cases they found that the unemployment rate was positively related to the failure rate of licensing exams in these three states. So, as the unemployment rate rose the failure rates on exams tended to rise. Thus, again the licensing exam can easily be viewed as a mechanism for restricting entry into the occupation in order to increase or maintain the incomes (and prices) of established, licensed practitioners.

A related method for occupational licensing boards to increase the income of the professionals licensed is to prohibit or enforce practices usually viewed as anti-competitive. For example, until very recently, lawyers' bar associations could legally circulate "suggested fees" for various legal services.

Another way for a board to enhance a professional's income to the expense of the consumer is to declare "unethical" such competitive practices as price advertising. Barbers, pharmacists, and optometrists, among others, have followed such a practice--resulting, of course in non-competitive price levels. In fact, a comprehensive study published in 1972 shows that restrictions on eyeglass price advertising by optometry examining boards increase the price paid from 25% to 100% more than in states which allow price advertising. A similar result also appears to be true for prescription drug price advertising. The Illinois Department of Registration and Education has moved to strike down these advertising prohibitions as has the Federal Trade Commission.

One direct test of the quality control argument is available. The FTC television repairmen study cited above found more fraud in the licensed state (Louisiana) than the unlicensed state (California). This, however, was most likely a function of the enforcement expenditures of the state rather than the fact of licensing. The study thus shows that registration of repairmen is sufficient for consumer protection purposes given active enforcement. Licensing is not necessary and will have no effect on fraud without active enforcement.

Unfortunately, little additional evidence relating to quality control appears to be available. Perhaps this is because it is inherently a much less quantifiable argument. How does one go about showing that removing the requirement that doctors be licensed will result in more deaths or injury due to medical malpractice? Society would have difficulty accepting such an experiment. Yet, it is true that the state does perform some quality control function through its licensing boards. It is, however, a very difficult factor to measure.

After reviewing the evidence discussed above, it is clear that the Federal Trade Commission's recent conclusion on the issue has a great deal of validity:

> "The theoretical argument that occupational licensing provisions would tend to increase prices appears to be supported by recent empirical work. The proposition is also supported by the unnecessary enthusiasm of members of various trades and occupations to become "regulated." They have perhaps learned from the trucking industry and airlines. It seems quite clear that substantial consumer injury results from a larger number of these licensure schemes."

Yet it also seems clear that the occupational licensing issue is essentially a question of degree: To what extent do elements of licensing restrict entry (and raise consumer prices) without at the same time providing for meaningful and necessary quality control.

For policy makers, the question may be restated: How much of occupational licensing can we eliminate or prevent without harming consumers by avoiding quality control responsibility? We now consider this issue.

One method of improving the state's existing occupational licensing program in the short term is to increase the number of consumer members on the examining boards. These consumers members hopefully can counteract the income-maximizing tendencies of price advertising.

Another method for improvement is conscientious review of existing licensing exams and board rules for non-quality related requirements by an outside party. This review has been completed in Illinois and national standardized tests have been adopted which prevent arbitrary failures and allow for reciprocity between states.

One excellent method of improving occupational licensing is to refuse to extend the system to another profession unless there is a clear and convincing showing that consumers are substantially harmed by incompetent professionals and that no other alternative would adequately serve purpose of consumer protection. This should be interpreted as a strict standard in order to stem the tide of the many occupations who would like state protection from competitive markets.

ALTERNATIVES TO LICENSING

Instead of, or in addition to, reform of the existing system, thought should be given to establishment or a less restrictive program altogether. For certain occupations, this can be accomplished by registration or certification.

A registration system would simply require individuals to list their names in an official register if they were engaged in certain occupations. While a fee may be charged, no evaluation of credentials and qualifications would occur. The marketplace would reward the qualified and the patently incompetent would tend to go out of business eventually. The registration fees may be used to investigate consumer complaints of fraud and inadequate work and take action thus tending to weed out the unethical and incompetent practitioners.

The important factor about registration and certification is that entry into the occupation is not restricted. Although such alternatives may not be feasible for all occupations (such as doctors), it is certainly clear that consumers would benefit (via lower prices) from applying such systems to many of our licensed professionals.

PROFESSIONAL ENGINEER REQUIREMENTS
and the
ROLE OF CONTINUING EDUCATION

Jerry S. Dobrovolny, P.E., Professor and Head
Department of General Engineering
University of Illinois

INTRODUCTION

In these days of consumerism much is being said and written with respect to the offering of professional services in a manner to protect to the utmost the public health, safety and welfare. The engineering profession has had a long history of addressing itself to competency requirements of its members. In the latter part of the nineteenth century a number of engineering societies, such as the American Society of Civil Engineers (ASCE) were formed and began to identify standards of practice to insure public health, safety and welfare. In the State of Illinois, the Illinois Society of Professional Engineers (ISPE) was founded in 1886.

In the first third of the twentieth century, many of the deliberations by engineering societies concerning the protection of the public began to be translated into state laws requiring the regulation of practicing engineers. The first of these laws was enacted by the State of Wyoming in 1907. Most states followed with their own laws and by 1930 there was a wide range of routes for entry into the engineering profession. The need for some consistency among the states was apparent. In 1932, ASCE adopted a Model Law for engineering registration.

Also in 1932, the Engineers' Council for Professional Development (ECPD) was organized to further bring together the various activities by the engineering societies in establishing a set of criteria to be used in voluntary accreditation of curriculums in colleges of engineering. Graduation from an approved curriculum is one avenue for entry into the profession as an engineer-in-training.

In 1934 the National Society of Professional Engineers (NSPE) was organized as an affiliate organization bringing together all of the individual state engineering societies such as ISPE. The National Council of State Boards of Engineering Examiners (NCEE) was established to coordinate the examining procedure in such a manner as to provide a standard throughout the state for persons entering the profession.

With this capsulated summary of the genesis of professional engineering registration requirements one can see that even as recently as forty years ago there was a wide diversion of approaches to registration among several states. Some of the problems that still exist need to be understood before one undertakes the topic of continuing education.

CURRENT GOALS OF REGISTRATION

In spite of the great progress that has been achieved over the last forty years in the area of professional engineering registration, several goals remain unattained. Perhaps the most important is that of the removal of the industrial exemptions. Even though a large number of registered professional engineers are employed in the manufacturing industries, the state laws do not require the designs of manufactured items to be sealed by a registered professional engineer. There are at the present time about 750,000 engineers in the United States with close to 400,000 being registered. Therefore, before any control with respect to continued competence requirements is concerned, the first step is to require all engineers working on designs relating to public health, safety and welfare to become registered.

Another area of goal attainment is the job entry requirements for entering the profession. It is generally accepted that before one can sit for the Engineer-in-Training examination, the person must be a graduate from an accredited engineering curriculum. In spite of this, most state laws still do not require a B.S. degree in engineering to become registered. The State of Illinois is one of the leaders in the movement and a B.S. degree in engineering is required before registration. The practice of engineering today is so dependent upon mathematical and scientific applications, it is impossible to function responsibly without at least a B.S. degree.

CHANGING STATE OF THE ART

The engineering profession is subject to the same "Future Shock Syndrome" as that of the rest of our society. In many respects the rate of change in engineering is even greater than in other facets of our society. The rapid developments in the use of computers, the use of mathematical modeling techniques simulating physical equivalents, new materials and a host of others make it mandatory for the engineer to continue to update skills to meet the needs of the people.

The realization for the need to conserve our natural resources and to maintain the quality of life in a pollution free environment, place further competency requirements on the practicing engineer. At the same time meeting the demands by society for more usable energy, a higher standard of living, more leisure time, full employment, etc., place the engineer in an unenviable position in trying to solve the technical problems of our age.

MAINTENANCE OF COMPETENCE

Engineering has been identified as a "Learning Profession." This connotes an immediate identification with the concept of continuing to learn new things to maintain one's competency in the field. The more traditional ways the engineer has used to maintain this competence are enumerated below.

Practice

It is becoming more and more accepted that one of the most important ways of maintaining one's competency is by practicing professional engineering. This forces the engineer to keep up with the latest developments in the field in order to remain competitive and competent. The very nature of the work of the engineer as a problem solver requires the use of problem solving techniques applied again and again. In many cases much of this updating is a result of self-study either by using more formalized methods or by studying the current literature in the technical journals.

On-the-Job-Programs

In many cases, when a company is involved with a new product line or a whole new process, the engineers -- singularly or collectively -- organize a study program. Consultants are often brought in to conduct in-service training sessions on the new material for the company engineers. In some cases formalized courses of instruction are structured to meet the specialized knowledge needs.

Technical Society Meetings

One of the most effective means for keeping up with the developments in the field is by attending technical society meetings. At these meetings papers are presented reporting on various research and developmental activities being worked on by other members of the society. The more significant papers are then published in the proceedings of the conference. These are reviewed by a peer group before they are published. The other papers are normally published as reports. Keeping up with the developments in one's field via the technical society journal proceedings route is an effective means of maintaining one's technical competence. The effort exerted is mainly on a self-study basis.

Seminars and Workshops

There are a large variety of seminars and workshops available to engineers on a wide range of topics. As new areas of knowledge are developed, these seminars provide an opportunity for the practicing professional to upgrade his knowledge rather quickly in a specialized field. The technical societies are getting more and more involved in this activity. Properly structured, a real service is provided for its members. Many universities are also involved in organizing seminars and workshops on technical topics. In the future both the technical societies and the universities will be even more involved in this kind of activity.

Graduate School Programs

In the final analysis the additional knowledge obtained by continuing on for a graduate degree in some specialized field of engineering is the most effective manner of insuring competency. It is becoming increasingly necessary for an engineer to obtain a Master's degree to practice engineering. In some highly specialized fields such as soil mechanics, a Ph.D. is becoming more and more common.

There is great debate with respect to obtaining a Master's degree in night school as opposed to being a full-time student. Many say being a full-time student is much more desirable. Of course, for some, this is not possible and a night school program is all that is available. In either case the competence is increased.

In many cases, courses are available on a televised network or in a phone hook-up. This enables a qualified teacher to reach a group of students scattered over a wide geographic area. This method has proven to be quite effective.

COMPETENCY REQUIREMENTS

The case for maintenance of competency is quite clear. However, the manner in which this competence is to be maintained and catalogued is not so clear. As has been enumerated above, there are many ways that an engineer has available to upgrade competency levels. During the last two years much has been discussed at various technical and professional societies with respect to how best to achieve the desired goal of maintaining competency. The State of Illinois Board of Engineering Examiners has had a sub-committee studying what has been occurring in such states as California, Iowa, Wisconsin, Florida and others. The Intersociety Meeting, bringing together all of the major engineering technical societies, held meetings in 1973 and 1974 addressing the problem of "Qualifications for Continuing Practice."

The American Society of Civil Engineers has studied the problem and has established a policy relative to registration, recertification and continuing education. The Illinois Society of Professional Engineers has established a task force to study the problem and to make recommendations in the near future.

CONTINUING EDUCATION UNITS

One of the proposed ways of accomplishing the objective of maintenance of competency is by each engineer accumulating a required number of "Continuing education units" over a period of years before registration is permitted. In some cases the formula is rather complicated and made up of a combination of the above mentioned ways.

More and more discussions lead to the conclusion that a formalized structured procedure for counting continuing education units for reregistration is NOT practical. There is no guarantee the units accumulated would add to the competency of an engineer -- particularly one who is practicing in a narrow field of specialization.

Another aspect that mitigates against this procedure is the impossible morass of administration that would be required in the State Office to adminster the program . Most state staffs are now understaffed doing the things ey are charged with doing.

REEXAMINATION

Another method that has been advanced is that of reexamination at specific intervals before registration is continued. The diversity of fields of engineering and the ever changing body of knowledge in these fields will make it difficult to administer the program. However, it remains as one way to go and that is to require specialized certification along with registration.

RULES OF PROFESSIONAL CONDUCT

Perhaps the most viable alternative is to have the engineer sign an oath each time he reapplies for his registration renewal. This oath would consist of a list of Rules of Professional Conduct developed by the Board of Engineering Examiners. These rules would include such statements as pertain to practicing in areas of competency and of maintenance of competency in the field of practice. This would provide a legal basis for enforcement and at the same time provide a viable way of administration.

CONCLUSION

The practicing engineer is bound by the ethics of the profession. As a professional the engineer voluntarily is committed to maintain a competency level consistent with protecting public health, safety and welfare. The first step in protecting the consumer is to require all of the engineers practicing to be registered. At the present time less than one-half of the engineers are required to be registered under law. Putting additional requirements on those already registered willnnot solve the problem.

The next step is to require all engineers, after they become registered, to sign the Rules of Professional Conduct as promulgated by the Board of Engineering Examiners. The ethics of the profession will go a long way towards the maintaining of competency upon re-registration.

The need for a wide range of opportunities for continuing education to maintain one's competency will continue to grow in the future. A collective effort must be undertaken by the leaders of the profession to insure the development of relevant programs to meet the needs of engineers.

COMPETENCY-BASED RELICENSURE

Robert K. Richards
Director, Office of Intramural Education
The University of Michigan Medical School

Licensure: Historic Development and Current Status

Licensure of physicians in the United States became a general requirement during the early 1900's and was developed primarily to establish and maintain adequate professional standards in medical education and practice.

Licensure laws and processes are enacted and administered at the state level as a joint effort of the regulated profession and state government. The customary standards for medical licensure are completion of a requisite amount of "schooling" in accredited institutions (e.g. graduation from medical school and completion of one year of House Officer Training) and attaining a satisfactory score on a written licensing examination. State licensure has subsequently been expanded to include professionals such as veterinarians, dentists, optometrists, nurses, pharmacists, podiatrists, chiropractors, psychologists, and nursing home administrators. Licensure statutes and processes are, typically, focused on the initial entrance into professional pratice in the state and, once successfully completed, are unlimited in time. Despite the trend toward specialization in many professions, licensure examinations still cover broad topics and require the professional to possess detailed knowledge in many fields. Once licensed, there are customarily no restrictions upon the scope of an individual's professional practice.

Medical licensure in the United States is currently a provincial process, clinging to standards of the past and administered as a minor function of state government by boards of volunteer physicians with limited expertise, staff, or budgets.

Cohen notes that the autonomy of a profession is critically linked to the credentialing system, where the basic prerequisites and standards are established for professional practice. The credentialing system in medicine includes (1) licensing by the state, (2) certification by specialty boards, and, (3) the accreditation of educational programs. Exclusive control of each element in the credentialing system is, Cohen states, tantamount to self-regulation.

Licensure is a key element in medicine's credentialing system, since it serves as (1) a means of public recognition, (2) protection from competition by the relatively untrained, and (3) a way of establishing pre-emptive jurisdiction over services that may be open to dispute. Although medical practice acts are justified in terms of protecting public safety, the actual factors accounting for such legislation can often be traced to sociopolitical considerations within the regulated profession.

Licensure, although formally a shared function with state government, is essentially within the control of the organized profession through their influence over the members of their profession appointed to the regulatory boards as well as their participation in drafting legislation and implementing regulations. Although state officials could be influential in this process they rarely are, due to the lack of expertise; preoccupation with other matters; and their reliance on the profession to function in this role.

Medical licensure, therefore, is a political process critical to the organizational autonomy and self-direction of the profession. Federal or state governmental threats of national licensure systems or conditions for periodic relicensure pose challenges which are vital to the organized medical profession.

The Development of Relicensure

The movement toward periodic relicensure in medicine is spurred by the vast growth of the past 25 years in biomedical knowledge and technology related to the diagnosis and management of patient problems. This "knowledge explosion" has led to growing concern within the medical profession, state government, and the public about its implications for physician obsolescence and continued competence.

The 1967 Report of the National Advisory Commission on Health Manpower recommended that professional societies and state governments explore the possibility of periodic relicensing of physicians based either on certification of acceptable performance in continuing education programs or on the basis of challenge examinations in the physician's specialty. This reflection of the need to safeguard the public against the practicing physician who has allowed lifetime learning habits to lapse signaled the beginning of a marked change since, at present, most states require only an application form and a modest fee to renew one's license to practice medicine and very few licenses are revoked through state board disciplinary procedures.

In 1971, legislation was passed in New Mexico which required physicians to complete 120 credit hours of continuing medical education (CME) in three years for renewal of their license to practice and to present evidence of compliance to the State Board. Similar laws have since been adopted in Maryland and approved, but not yet implemented in Kansas and Kentucky. Within the past year, CME for relicensure laws linked to efforts to solve the malpractice insurance crisis have been enacted in Michigan, Ohio, and Wisconsin. Currently, New Mexico is the only state to have completed a relicensure cycle. The vast majority of that state's 1200 physicians complied with the CME requirement, although some physicians retired or left the state and a small minority contested the requirement in court.

Periodic re-examination as a method for relicensure was proposed in the 1967 Health Manpower Commission Report. Regarding re-examination as a basis for relicensure, Dr. William N. Hubbard, Jr., points out,

> Re-examination of practicing physicians could give artificial reassurance. Passing an essentially

> factual examination means only that the raw materials for rational professional practice are present. It does not measure the quality or the actual value of the physician's efforts. Although superficially plausible, the idea or re-examination...evades the central issue, which is to develop a set of criteria that will assess the true value of a physician's services.

In 1974, the American Medical Associations House of Delegates encouraged expansion of CME, including efforts to measure physician performance and learning needs related to actual patient care but recognizing that the criteria and methods of effective CME, performance evaluation, and challenge examinations are far from perfected; questioned whether incorporating them into periodic relicensing legislation would result in real improvements in medical competence. They conclude:

> For this reason, proposals in federal legislation for national relicensure of physicians...are ill advised, would be cumbersome to implement, and could have serious effects on the availability of health care without producing any increase in quality.

Public Accountability and Competence

Traditionally, medical education and organized medicine has preferred to deal with issues focusing on the quality of education and medical care - and medicine is substantially ahead of other state-regulated professions in its self-imposed requirements for continuing education and for quality assessment. Were it not for the critical social importance of medical care and the growing public dissatisfaction with access to care, its rapidly rising costs, and publicized cases of malpractice and ethical violations, it is unlikely that medical relicensure would have been selected as an area requiring governmental regulation to assure public accountability.

Felch defines accountability as assurance to the public by the medical profession that the medical care delivered is appropriate. Assurance to the public, he notes, requires a system to assess the quality of care. While many individual assessment activities are operative at present, a systematic approach is non-existent.

The medical profession is concerned with upgrading the quality of medical care--with strengthening and extending the best of the profession. It is motivated to act by the quality implications of the vast growth in biomedical knowledge, a concern for public accountability, professional prestige, and of course, to forestall governmental regulatory actions.

The public and, particularly, government is somewhat less concerned with medical quality and much more with access, cost, and with publicized cases of incompetence. Given these biases, the profession will seek to emphasize optimal standards, while government will stress minimal standards--to protect the public against incompetent or unethical practice.

Relicensure is mandated by governmental legislation and focuses on assurance to the public that all physicians meet minimal standards of competence.

Is Competence A Problem?

Current problems related to medical relicensure include: (1) foreign medical graduates, some of whom have inferior education, training, and cultural assimilation; (2) physicians with sociopathic problems who have been protected by the laissez faire approach to relicensure and disciplinary processes in the past; and (3) problems in medical quality assurance surfaced through malpractice litigation all suggest a proper basis for concern by government regarding the competence of some licensed physicians.

Derbyshire states, "At least five percent of the nation's 350,000 doctors are incompetent...meaning they are treating--ormistreating--approximately 7.5 million patients a year. In these physicians' hands, the license to practice medicine becomes a license to kill. I've seen lives lost because doctors haven't kept up with new techniques."

Jervey estimates that within the legal concept of the problem, from one to three percent of the physician population represent disciplinary problems and the number involved in ethical considerations would be substantially higher.

An Approach to Competency-Based Relicensure

Neither an extension of the currently popular mandatory CME for relicensure regulations nor the imposition of periodic re-examination of cognitive knowledge as a requirement of continued practice will assure the public of the ongoing competence of physicians. Provision of this assurance is possible only through carefully developed standards and processes for periodic competency-based relicensure.

There are many problems inherent in developing a competency-based relicensure system, however, and even given concerted efforts by organized medicine and governmental support, it is an unlikely development within the next four years.

Any approach to competency-based relicensure will have to take into account the complexity and diversity of medical practice. After the broad curricular scope of the early experiences in a physician's career (i.e. medical school and licensure examination) the years of graduate education and practice lead toward increased specialization. Major influences on an individual physician's practice experiences are his/her own choice of specialty and practice location, the problems presented by the patients who choose him/her as their physician, the specialty configuration of local physician colleagues, her/her referral availabilities and habits, and the human and technological resources of local hospitals.

Since physicians' experiences become increasingly differentiated under practice conditions, it is essential that any attempt to assess physician competence begin with standards and methods that can be tailored to differentiated practice circumstances.

Since legal decisions are stressing, increasingly, a national standard for competent medical performance, it also seems important that these minimal standards be national in scope. Development of these standards will require the unique professional knowledge of a broadly representative group from organized medicine to establish and update the standards.

Once developed, the standard-setting process should be encoded into either national or model state-adopted relicensure legislation.

Revitalized and expanded state medical practice boards, with adequate staff expertise and budgets, would be required to carry out licensure and relicensure responsibilities.

One possible approach to competency-based relicensure will be presented as an example of a potentially workable approach to this objective:

> A differentiated approach to competence assessment and relicensure could begin by adopting a profiling process to identify the most frequently encountered patient problems of an individual physician's practice and, based on the profile, to select applicable profession-developed performance standards for those problems in which physician behavior has a significant impact on outcomes.
>
> Following the profiling of an individual physician's practice and the identification of applicable performance standards, the relicensure process could require a review of a sample of his or her office and hospital patient records and comparison of their performance against the appropriate minimal standards.
>
> Measurement of a physician's knowledge related to his/her profile of patient problems or, alternately, acceptance of evidence of participation in formal CME programs related to these problems, could be a second part of the relicensure requirements.
>
> A third relicensure requirement could be demonstration by the physician of potential competent performance in critical, but rarely encountered, practice eventualities such as resuscitation of a patient with cardio-pulmonary failure. Potential competent performance could be assessed by recently demonstrated, satisfactory handling of such emergencies or through simulation.

> A final requirement could be the maintenance of acceptable standards of professional and ethical behavior and might include a review of patient or peer complaints, hospital staff disciplinary actions, malpractice suits and cases, or other applicable data.
>
> Given the minimal character of these proposed relicensure standards and the expense and time requirements for reviewing an individual physician, a three year relicensure cycle would seem adequate to provide reasonable assurance to the public of a physician's ongoing competence.

Over sixty years ago, Flexner cautioned, "The power to examine is the power to destroy." Implementation of relicensure standards, particularly those that are performance based, would pose a threat to the continued livelihood of some physicians. The standards set for relicensure should, at least initially, allow over 95 percent of American physicians to gain relicensure without undue difficulty.

The remaining five percent, over 15,000 physicians, will provide enough difficult judicial and ethical problems for the medical practice boards and for the limited resources available for the rehabilitation of those physicians who present competence problems. It would be naive to implement such an approach to relicensure unless we, as a society, are willing to support the costs of the process and to remove the licenses to practice from one to two percent of American doctors, following due process and rehabilitative efforts. Some of the physicians with competence problems will, undoubtedly, be found in areas critically short of doctors. The increased supply of physicians now in undergraduate and graduate education and an effective mechanism for dealing with current geographic and specialty maldistribution problems would be prerequisites to any effective standards for relicensure.

Summary

If relicensure of physicians is to assure the public of practitioners who meet minimal standards of professional competence, then only a competency-based approach will meet this objective. While mandatory participation in CME or periodic re-examination of knowledge and skills may be useful components of a competency-based approach, they will not, by themselves, provide this public assurance.

Progress toward competency-based relicensure will require significant investments of funds and effort in defining minimal competency levels and development methods to measure physician performance. It will also require a close working relationship between federal and state government, medical education, and the organized profession.

A competency-based relicensure system must (1) provide reasonable protection for the public, (2) be acceptable to the organized profession,

(3) assure realistic standards and due process for the individual practitioner, and (4) be within the resource capabilities which government and organized medicine are willing to assign to this societal function.

The current trends in medical relicensure are of great importance, since they seem likely to affect societal standards and processes for the public accountability of all licensed professionals.

Bibliography

Brown, Clement R. Jr. and Uhl, Henry S. M. "Mandatory Continuing Education, Sense or Nonsense?" JAMA 213 (September 7, 1970): 1660-1667.

Cohen, Harris S. "Public Licensure, Organizational Behavior and the Public Interest." The Milbank Memorial Fund Quarterly 51 (Winter, 1973): 73-93.

Department of Health, Education, and Welfare. Developments in Health Manpower Licensure. New York: Department of HEW, 1973.

Derbyshire, Robert C. Medical Licensure and Discipline in the United States. Baltimore: The Johns Hopkins Press, 1969.

Dubin, S. S., ed. Professional Obsolescence. Lexington: Lexington Books, 1971.

Felch, William C. "Recertification." Eighth National Congress on the Socioeconomics of Health Care, Talk, April 19, 1974.

Flexner, Abraham. Medical Education in the United States and Canada. Boston: D. B. Updyke, Merrymount Press, 1910; reprint ed., Washington, D.C.: Science and Health Publications, 1960.

Friedson, Eliot. Profession of Medicine. New York: Dodd, Mead, and Company 1973.

Kennedy, Edward M. In Critical Condition. New York: Pocket Book, 1973.

Miller, George E. "Continuing Education for Waht?" Journal of Medical Education 42 (April, 1967): 320-326.

Report of the Secretary's Commission on Medical Malpractice, by Wendell C. Freeland, Chairman. Washington, D. C.: U.S. Government Printing Office, 1973.

Report of the Committee on Goals and Priorities of the National Board of of Medical Examiners, by William D. Mayer, Chairman. Philadelphia: National Board of Medical Examiners, 1973.

Report of the Nader Study Group on the Medical Profession's Performance in Self Regulation, by Robert McCleery, Study Director.: Public Affairs Press, 1971.

Report on Licensure and Related Health Personnel Credentialing. Washington, D. C.: Department of HEW, June, 1971.

Report of the National Advisory Commision on Health Manpower, by Irwin J. Miller, Chairman. Washington, D. C.: U. S. Government Printing Office, 1967.

Ribicoff, Abraham. The American Medical Machine. Harrow Books, 1972.

Shryock, Richard H. Medical Licensing in America, 1650-1965. Baltimore: The Johns Hopkins Press, 1967.

GREATER ROLE FOR UNIVERSITIES IN SETTING STANDARDS FOR THE PROFESSIONS

Philip E. Frandson
Dean, UCLA Extension

How a person gets into a profession and how he maintains that status have become disputed issues in the developing conflict between the professions and the public.

Last week for instance, delegates to the State Bar annual convention disapproved a proposal to require periodic relicensing and continuing education of lawyers. On the other hand, Gov. Brown recently signed a bill giving non-lawyers a voice in governing the state's 45,000 attorneys, although bills to give consumers a larger role on state boards concerned with other professions were defeated this year in the Legislature.

The controversy involves the makeup and status of regulatory boards, the role of colleges and universities in the relicensing process, and the moral and ethical issues of responsibility and control.

Who has the right to control the licensing and/or relicensing of doctors, nurses, lawyers, engineers and other professionals who hold the lives and fates of people in their hands? Who has the responsibility for setting the standards the professionals must live up to? Who will ultimately control the content of laws regulating continuing education requirements for relicensure?

Who will watch over the delivery of professional services to the public, and evaluate performance in accordance with the established standards? Who will judge the end results? Can these functions safely be left solely in the hands of the professional association?

Until just the last few years, there has been a propensity to operate as if some unwritten law delegates all authority to professionals. Presumably, if they had fully lived up to the responsibilities inherent in such total control there would be no questions to ask--and no pressure for change.

But there is pressure, and the questions are being raised: questions about how self-policing, self-regulatory associations can ever be wholly concerned with the interests of those for whose lives and welfare they are responsible, rather than primarily with their own self-interest; questions whether commissions and boards appointed to protect the interests of the consumer can be truly objective if the overwhelming majority of their members are also members of the profession they regulate; questions as to who shall decide where to draw the line in the licensing and relicensing authority of the boards and commissions.

On the one hand there is the danger of licensing persons unqualified to practice--and on the other the danger of restricting practice so tightly that there are not enough licensed practitioners to meet the demand. In the field of continuing education there is the question of who shall be responsible for the actual offering of courses. Shall the professional associations, who set the standards and provide the major membership of the licensing boards, also control the offering of continuing education programs designed to validate relicensure?

Clearly in the complex of these questions there lies unlimited opportunity for integrity and responsibility and trustworthiness. But there also lies the opportunity for the unscrupulous few to restrict and discriminate, to corrupt the use of education as a basis for relicensure, and to turn to financial gain the processes initiated for protection of the people. The monumental moral issue is, of course, conflict of interest.

New voices are rising, each calling for a role in its own constituency--elected officials, consumer protective associations, continuing education divisions, to name only a few. They do not deny that the professional and the professional associations have the right to control their own destinies. But wherever these destinies merge with the law and with public policy concerning licensing boards, continuing education, accountability, performance evaluation--then unless control is shared with other concerned constituencies the possibility of nonprofessional, immoral and corrupt practice cannot help but exist.

To the reformers, government and the law seem too readily used by the established high-income occupational classes to protect their privileges status and to corner the benefits of society.

Before the California laws regarding relicensing are made final, it is important that every concerned citizen be aware of the implications of these laws--and of the differences between a good law and a bad one.

One way to begin is to draw up a list of the key issues of professionalism that are involved in licensing, practice and relicensing, and a list of the concerned constituencies that seek full or partial control and authority over each of these key issues.

As I see it the primary issues are philosophy of the profession; ethics of the profession; law, including the right to practice; delivery of service to the public; accountability, both for service or supervision of delivery, and for evaluation of performance and results; and finally, continuing education of the profession.

The principal concerned constituencies include the individual professional; the professional association; government (legislative, executive, and regulatory commissions or boards); the public, individually or as represented by consumer interest groups; and the colleges and universities through their professional schools and continuing education divisions.

My own primary concern is with the role of the colleges and universities in legislation to regulate the professions.

I would concede the philosophy and ethics of the profession to the professional associations, with possibly some consultative help from the public.

With regard to the law, including the right to practice, final responsibility lies with governmental units--legislative bodies in writing the law; the executive in approving; and whatever board or commission the law establishes, in assuring that it is carried out.

The ultimate influence on what the policy-makers write into the laws--that is, the setting of standards in education, competency, experience and talent on which these laws shall be based--must come from the profession itself, based on ethically motivated concepts of self-regulation.

It is essential however, that institutions of higher learning play a statesmanlike role in development of highest standards in the law. It is from these institutions that research knowledge largely emanates. They are the storehouses of knowledge as well as the creators and disseminators of the newest in research. And continuing education--which is an integral component of relicensure--is inseparably united with research knowledge.

The universities, therefore, should take leadership in developing a team approach to the writing of the law, not only,for essential academic suggestions and contributions, but to protect the public interest by assuring that professional practitioners be fully qualified, available in sufficient number, and required to stay abreast of the highest standards and latest advances in their fields.

As for delivery of service to the public and accountability, the universities would play a role in providing informational programs for the client-consumer, and training programs for professionals and for governmental agencies in such areas as medical care audit, evaluation of transportation systems, etc.

These components of the delivery and accountability issues overlap the continuing education of the professions. And it is on this final issue that I take the strongest stand for the total involvement of our institutions of higher learning.

Traditionally it has been the universities that have had major responsibility in this area. Now, however, not only is any idea of exclusivity gone, but some professions are moving in the direction of eliminating altogether the role of the colleges and universities. I would agree entirely that the professional associations should be concerned with setting the standards for continuing education--but the universities must be the primary implementing agency. The universities are the greatest single source of new knowledge in the professions, and by virtue of this, also the greatest single knowledge resource, through the faculties of their professional schools, and the continuing education divisions that open university talent, research and resources to the adult community beyond.

In addition, through the universities there is available an all-essential ingredient not found in any single professional association. That is the multiprofessional viewpoint regarding the great issues of the day. Rarely does public decision-making today involve a single narrow disciplinary line. The practice of medicine, for example, which has long involved also the life sciences and physical sciences, now spills over into engineering, the law, management, and even the arts as in music therapy. The university, particularly in its centralized continuing education division, concentrates a single source of multidisciplinary knowledge.

I do not deny that the movement within some professional associations to develop their own continuing education programs is a healthy thing, because through such programs association members profit from the experience of their fellows. But if such programs are presented to state legislatures as evidence that associations should be solely responsible for continuing education, the potential for conflict of interest sanctioned by the law is all too clear.

Even an open-ended law, stating that continuing education may be taken by professionals either from their associations or from accredited institutions of higher learning, can be dangerous--if there is no requirement for an equitable balance between programs from each source. Failing such a requirement, the danger is that the professional could go through life without ever being exposed to the latest, the highest-and-best in the realm of pure research in the field--and that the professional associations may totally control in a restricitve, narrow fashion an area of crucial concern to the public they serve.

We must make sure that our state laws mandate the role of the universities in standard-setting, planning, development, presentation and evaluation of results, for all aspects of continuing education programs leading to relicensing in the professions.

PROBLEMS IN THE ADMINISTRATION OF MANDATORY CONTINUING EDUCATION REQUIREMENTS

C. Dale Greffe, Chairman
Professional Engineer Examining Committee

In recent years public attention has been focused on professional practice. Nader's UNSAFE AT ANY SPEED some ten years ago and the activities of Nader's Raiders in and out of Congress and the Washington scene since that time have done much to intensify that attention. About that same time a well known Dean of a college of engineering at a midwestern university added a dramatic touch to the picture with his statement that "the half-life of an engineering education is five years." This statement has been quoted in and out of context many times since then. In fact, some mistrust for engineers and engineering has developed as a result of this playful remark. A question being asked is, "Do the laws which regulate the practice of professional engineering really safeguard life, health and property?"

It is not the purpose of this workshop presentation to deal with this question. The purpose for this workshop is the consideration of 'problems in administration of mandatory continuing education requirements.' However, I am going to ask that we all think of this as the mandatory continuing professional development requirements. All too often the fact that professional practice results in educational experiences of considerable value is overlooked.

Examples used in these preliminary remarks are related to the engineering profession. However, the requirements for registration in any of the professions pose problems differing very little from those discussed here.

The 'Model Law' of the National Council of Engineering Examiners specifies a 2-day, 16-hour written examination for registration of the professional engineer. The first day of the examination, which is prerequisite to certification of Engineer-In-Training (EIT) is intended to cover the engineering fundamentals common to approved curricula in all engineering disciplines. The second day of the examination covers the applications of the fundamentals in the practice of professional engineering.

Completion of a 4-year approved curriculum in an engineering discipline is required for admission to the first day of the examination. The accumulation of an additional four years of professional experience acceptable to the professional engineering examining committee is required for admission to the second day of the examination. Successful completion of both parts of the 2-day (16-hour) examination is prerequisite for registration as a professional engineer. In several states the term 'approved engineering curriculum' implies approval by the Engineering Council for Professional Development (ECPD).

From this brief review it can be concluded that a combination of formal course work and experience gained in the application of engineering fundamentals to the solution of engineering problems constitute the preparation for engineering practice. Because of the lack of uniformity in state laws which regulate engineering practice some states permit substitution of professional experience for the formal education requirements.

It should be noted that the examination process merely establishes the fact that the applicant has gained at least a minimum know-how to practice professional engineering.

Any attempt to discover all of the problems associated with the administration of mandatory continuing education requirements would serve no useful purpose without a full understanding of the individual requirements.

It is possible that the legislature might define in great detail what constitutes 'continuing education.' The text of the the law could establish the types of professional activity that would meet the requirements for continuing education. It could provide a table of values for those activities acceptable for the purpose. How complex such detailed information could become would depend upon the diversity of available educational devices within the given profession. It is also possible that the text of the requirements might be worded in very general terms. In this event the responsibility for working out the details would fall upon the examining committee.

Problems that will be encountered in the administration of mandatory continuing education requirements include:

Identification
Verification
Background preparation of registrant
Logistics

While this list does not include all of the problems that may be encountered, it does include those of major importance. It is true that the problems of reciprocity or comity between states become critical as the registration requirements become more complex. Even so, this problem has not been included as a part of these preliminary remarks. A brief discussion of each of these problems will follow in the order given.

There is little doubt in my mind that the problem of identification is the greatest of all of the problems to be encountered. What constitutes continuing education? How is it to be achieved? Forty years ago the problem did not exist; or if it did exist, we were generally unaware of it. The technical societies, through publication of technical journals and transactions, and regular monthly meetings of the membership provided up-to-the-minute information on new discoveries and newly developed techniques for their applications. Today, the degree of sophistication in our profession precludes the possibility of meeting the needs of the practitioner with such antiquated devices. What constitutes an adequate program for continuing education?

Will continuing education be limited to formal course work taken under college controlled classes?

Will such devices as seminars and non-credit short courses have educational value? We are all aware of the tremendous number of seminars and short courses currently available.

As mentioned earlier, some professional practice is prerequisite to professional registration. Will it be possible to meet the continuing education requirements through high level professional practice?

Does the experience gained while directing professional work of others have educational value?

Will the publication of technical material meet some or all of the requirements.

Will attendance of technical meetings and participation in their programs have educational value?

Will it be required that these educational experiences relate directly to the professional's area of expertise or field of practice? It appears to me that one could become involved in an extensive aducational program without enhancing his skills or know-how in his area of practice. Is it possible that an educational experience in one professional area might not qualify as an educational experience in some other area?

In the administration of an effective program of continuing education requirements, these questions must be answered. Perhaps this list of questions is incomplete. In any case, it will be necessary to identify every type of professional activity in terms of its educational value. Identification is the key word.

This workshop was planned for the discussion of problems in the administration of mandatory continuing education requirements. In many cases, we must discuss these problems without knowing what requirements have been legislated. For most professions these requirements have not been established. We fear the worst and hope for the best! If the requirements are spelled out in terms of formal course work in college verification can be no more complex than an official transcript. If the requirements are completely general, lacking in specificity, verification could be little short of the impossible.

Some have suggested that peer groups in local areas be set up to verify continuing education activity. Others have suggested that the technical or professional societies assume responsibility for maintaining records for continuing education credits earned by members of the profession. Still others have hinted that this verification is a good and proper activity for the professional examining committees. In any case, it should be apparent that professional skill would be required to identify and verify each item of continuing educational experience. In any profession, registration must have a beginning. In the beginning each registration act must provide for those professionals who were practicing when the act became law. For these persons prerequisites were waived, where necessary, to avoid the process of taking away his means of making a living. That is, each act has a grandfather clause under which many registrants were permitted to continue professional practice even though they did not have the minimum qualifications specified in the act.

The history of any registration act reveals an evolution of upgrading. The present wording may specify requirements that are far more demanding than those in its original wording. As a consequence, some of the registrants are extremely well qualified, while some are very poorly qualified.

The experience record of each registrant will reflect which continuing education program would best serve his purpose. Any program which ignores this record of preparation and practice would probably fail to improve his performance capability.

Records in the Department of Registration and Education in the State of Illinois contain names of more than twenty-five thousand registered professional engineers. This number is increasing. Two examinations are held each year. As many as twelve hundred applications for admission to each examination are received. Each application must be reviewed before the applicant is admitted to the next examination. The process of reviewing each application requires the ability to recognize professional activity. Such responsibility cannot be delegated to lay persons.

If it becomes necessary for the renewal of registration to reflect continuing education, each registrant's experience record must be updated. Such a process would require many hours of professional effort. The problems of identification and verification would make the process of updating the registrants' records anything but routine.

In any set of mandatory requirements for continuing education it will be necessary for complete identification of all activities that may qualify. A system which will verify all claims for continuing education credit must be developed. It appears that such a system must be capable of recognizing the value of educational experience in terms of the registrant's needs for keeping his practice up to date. Such a system will be administered by the Department of Registration and Education. It should be complex enough to be effective, but simple enough to be administered.

IV

PROFESSIONAL ASSOCIATIONS PROFESSIONAL SCHOOLS, AND CONTINUING EDUCATION

THE PROFESSIONAL SCHOOLS, THE WORLD OF ENGINEERING PRACTICE, AND CONTINUING EDUCATION

Daniel C. Drucker
Dean, College of Engineering
University of Illinois, Urbana-Champaign

First I should establish my credentials as a long-standing advocate of continuing education to meet the needs of engineers in practice. Over twenty years ago I wrote and spoke on the rapid, ever-accelerating advance of engineering practice and the underlying theory, the obvious difficulty engineers faced in keeping up because even then they were flooded with bad as well as good technical literature. I pointed with alarm to the devastating effect of technical obsolescence. I organized special seminars and lectures through local branches of the engineering societies in Providence, Rhode Island, and arranged convenient hours for the taking of formal courses at Brown University.

Despite the great need, the net result of my periodic flurries of activity was repeated disappointment. The need was there, and the offerings were tailored to that need as described by practicing engineers in response to questionnaires, but the demand was miniscule. If not for the attendance by those who really didn't need the material presented, the poorly attended meetings would have been downright embarrassing.

Twenty years ago forward-looking schools of engineering had just been through the exciting but painful process of a dramatic updating of their educational philosophy and course offerings. Mathematics and the physical sciences formed a firm base upon which engineering sciences were built. They, along with an introduction to the practice of engineering, provided a new springboard for launching the engineering graduate on a successful career. Twenty years ago, with the adoption of the Grinter report, the remaining engineering schools also embarked on this needed revolution in engineering education. The technical achievements of the past two decades bear ample witness to the effectiveness of the new breed of engineer.

Such an abrupt educational revolution in response to a genuine requirement of the profession leaves the majority of those in practice in a position of inadequate preparation difficult to overcome solely through self-study. Keeping up with evolution is hard enough!

Evolution of knowledge has been accelerating in the intervening years as it has done for decades and centuries earlier. Twenty years ago only a small fraction of all engineers under the age of 35 had master's degrees. Today over half do and the ratio of master's degrees granted each year to bachelor's degrees granted each year continues to climb. Considerable numbers now study for and achieve a doctorate; the knowledge base in the physical sciences has been expanded to include all the natural sciences. Certainly it is true that without formal or informal continuing education, the practitioner year by year falls further and further behind the level of the background of the newly graduated engineer-in-training.

Yet this broadening and deepening of engineering education that took place since World War II is only the forerunner of giant new steps in engineering education. We expressed our perception of times to come in a proposal from the College of Engineering on the Urbana-Champaign campus of the University of Illinois, to the Alfred P. Sloan Foundation, a proposal that was funded in 1972 and has had a profound beneficial effect whose influence continues to spread. Our philosophy of the desirable engineering education of the future was summarized as:

> "The goal of the engineering education we visualize is exceedingly ambitious and far beyond the limits of our present knowledge and capability. Only a bare beginning is possible. The principal purpose of engineering education has always been to provide the engineering student with the basic tools and viewpoints for a good start in the practice of engineering, and to prepare him adequately for a lifetime of learning and intellectual growth. His education is supposed to equip him to do his part to advance technology in accord with the needs and aspirations of society. The definition of engineering employed by educators and practitioners alike includes the phrase "for the benefit of mankind."
>
> The beginning we propose contains a mechanism to translate this phrase rapidly and pervasively into educational practice and to begin to give it equal operational weight with the description of engineering as "based on the natural sciences and mathematics." Social and humanistic studies must then become as integral a part of the engineer's education as mathematics and the natural sciences now are. Fundamental courses in the social sciences and humanities, now required in all curricula, are essential but insufficient by themselves. Their tools, concepts and values, with all their rich variety and enormous uncertainties, must be utilized as directly in engineering courses as the tools and points of view of mathematics and the natural sciences which although very different also deal with an ever-changing and largely unknown world of knowledge. The engineer cannot be expected, of course, to become any more of a social scientist or humanist than he now is a mathematician or natural scientist.
>
> The eventual goal is to educate engineers who will be capable of planning and designing alternative technologies for the future among which informed choices can be made on the basis of individual and social goals, given the restrictions of cost and technical feasibility."

Even without this highest order of societal responsibility that the engineer must learn to integrate effectively into his or her technical activity, the need for continuing education today is enormously greater than twenty years ago. Surely, then, the demand for continuing education by the million or so working engineers of the nation must be enormous.

Not at all! Today, as twenty years ago, the demand is negligible in comparison with the need. Many more short courses, special courses, special lectures, and special sessions are available and attended today. Commercial firms and a few universities actually are making money responding to this market. Yet it remains true for the most part that the attendance at sessions that bring you to the forefront of current practice is mainly by those already at or close to the forefront.

In puzzling once again over the great discrepancy between need and demand, as I prepared for this talk, some new thoughts came to me which I should like to share with you and to which I hope you will react.

Engineering has differed significantly from most of the professions because engineering involves team effort among engineers on a very large scale in addition to the customary interaction of professionals with society. Successful engineers in industry, government, and private practice "progress" (and I place progress in quotes) from knowledgable experts in one of the engineering disciplines to managers. First they are managers of technical teams, then managers of projects, and then managers of organizations. Success as measured in peer esteem and especially in financial rewards, means leaving special disciplinary competence in the direct technical sense and replacing it with broad disciplinary and interdiscilpinary understanding.

I used the term "engineering has differed" because there are strong trends in the practice of medicine and law toward the pattern of engineering, including the educating of sufficient numbers that only a small fraction of the graduates can aspire to positions of high prestige.

It is interesting that, almost alone in the broad spectrum of engineers, educators must stay at the very forefront of disciplinary knowledge in engineering to be viewed by their peers and their students as successful. Continuing education for them is a way of life. Continuing education for those engineering educators who have permitted the world to pass them by, or for those in necessarily increasing number who wish to move to a quite different branch of engineering, poses difficult and interesting problems. Their relevance to continuing education for engineers in industry, government, and private practice is somewhat remote and will not be given attention here although many of us on campus spend much of our time thinking about them. Considerable shifts in field are essential over a 40-year tenure even though it is not true that existing engineering knowledge becomes obsolete in 10 years. To get some picture of the change in engineering or medicine 40 years from now, and the adaptation that will be needed in the interval, imagine yourself back in time not 40 but more nearly 80 years before the turn of the century. Catalog the changes from then to now.

A thought to which I would welcome your reaction is that the equating of success with managerial or administrative activity accounts for a variety of phenomena that frustrate many sincere efforts to provide continuing education for engineers. Let me refer to our experience in Peoria which was duplicated later in Springfield. The Urbana-Champaign campus along with Bradley University and Illinois Central College cooperated in a joint effort to present some interesting sessions for engineers of the area and in turn find out what demands for continuing education existed that we could meet individually and jointly. Attendance was high at the opening session. Many made a considerable effort to get to the meeting and were glad to invest appreciable time and some money. The handful of personnel people who were present thought that the engineers needed and would want to know more about such important topics as the analysis of stress and strain, the avoidance of fracture, the design of mechanisms, etc. The engineers who were present knew that was exactly what they did not want. They opted for a quick guide to becoming an effective part of management.

Advanced design in industry, using modern computer techniques and fundamental knowledge, is a young person activity. By age 35, with a few very important exceptions, the brightest people are asked to be technical managers. They then become too busy to pay attention to details. They move on to project management and rapidly lose track of the latest techniques of analysis and current advances in fundamental understanding. By age 45 the process is almost complete.

I should remind you that most of the spectacular failures of the past have been in failures of detail as in the Quebec bridge, failures of understanding as in the Tacoma Narrows bridge, or of both as in the windows of the John Hancock building in Boston, the splitting in two of cargo ships at sea, and the cracking of stainless steel tubes in power plants.

Yet if the financial rewards and the prestige go to managers, and if at age 40 technical work at any but the highest level of research development or consultation is viewed as an inferior occupation, why should we expect a high demand for technical continuing education? Many engineers below age 35 or 40 will be studying for advanced degrees and many will volunteer for continuing education. Those above 40 who have not achieved acknowledged expertise in a technical discipline may well be embarrassed to be seen taking any part of a technical continuing education program.

Do management courses and lectures and workshops connote success for the older engineer, the vast majority of engineers who need continuing education, while the corresponding technical activity connotes failure? More generally, is it that any expression of need for technical continuing education is an admission of failure for anyone not obviously a success?

This distinctive managerial feature of successful engineering also may be a major factor in accounting for the almost unanimous opposition of professional and technical engineering societies to mandatory continuing education. They are on record in opposition to re-registration of professional engineers as unnecessary. They have stated firmly that if re-registration is required, continuing education should not be mandated. Instead, re-registration should depend solely on evidence of successful practice. This negative position may or may not prove tenable in these days of sometimes valuable and sometimes misguided consumerism, but it is not unreasonable. Engineering covers so many diverse fields that the protection of the public cannot be assured by examination or education. Protection of the public requires the ethical concept of each engineer engaging only in those engineering activities in which he or she is competent. No amount of initial education or continuing education will enable one person to know more than a small fraction of all of engineering.

The voice of the engineering societies is the voice of the successful. Except for a fairly large number of engineering educators, the councils of the engineering societies are composed of engineering managers from industry, government installations, and private practice. They are fond of continuing engineering education for those in subordinate positions and the societies are now taking an active role in providing continuing education for their members and informing them on the opportunities available at universities and elsewhere.

However, they view the thrust toward mandatory continuing education as a plot on the part of educators and commercial firms to produce a demand for their services, to increase the level of their business. They are disbelievers in statements from educators claiming an altruistic protection of the public and advancement of the profession. They tend, therefore, to favor short courses in conjunction with meetings of their societies or courses they sponsor that are taught by engineers in industry or jointly by educators and engineers-in-practice. Societies hold many "Applications Sessions" at meetings to present existing practice. These supplements to the advanced technical sessions, which form the heart of most programs, sometimes attract large audiences, sometimes attract very few. Continuing education units may or may not be preferred. Costs may be high or low. Again, however, most attendees are remarkably knowledgeable folk who wish to sharpen their understanding.

The supposed vast demand I have been expecting for decades has yet to materialize. Perhaps the real need is not nearly as great as calculations of technical obsolescence suggest. Perhaps the equating of a managerial role with success eliminates those who might benefit most from technical continuing education. Certainly it is an important factor in engineering society opposition to mandatory continuing education for professional re-registration.

PROFESSIONAL STANDARDS, COMPETENCY, AND CONTINUING EDUCATION: ROLES AND RESPONSIBILITIES OF PROFESSIONAL ASSOCIATIONS

William K. Selden
Princeton, New Jersey

Upon receipt of the invitation to join you at this conference on mandatory continuing education and after reviewing the preliminary program of activities I reflected for some unidentifiable reason on the mythical story of "Alice's Adventures in Wonderland."

You will recall that in that story young Alice was distracted from her reveries one sunny afternoon by sight of a white rabbit with pink eyes, a sight not so remarkable in itself. However, this white rabbit was wearing a waistcoat from which she saw him extract a watch. Glancing at it in great haste and then exclaiming audibly, "Oh dear! Oh dear! I shall be too late!", the rabbit hurried away, now followed by Alice whose pursuit led her down a large rabbit-hole into a land of new adventures and strange experiences. Here she consumed liquids that expanded her height, ate foods that contracted her size, and encountered animals of all kinds that could talk, as well as a royal couple who held court among this varied menagerie.

One might conclude that Alice's experiences were a form of education, but in the context of this conference would they qualify as continuing education? Compared to what I have been told about some courses that have been offered on cruise ships or at other glamourous spots, the course conducted by Alice's friendly rabbit might well qualify and be accredited.

You may further recall that in her inquisitive quest for information and knowledge Alice inquired of the Cheshire Cat, "Would you tell me, please, which way I ought to walk from here?" To this query the Cat replied. "That depends a good deal on where you want to get to." I judge that one of the main purposes of this conference is to identify where we want to get to.

To help us find the answer to that basic issue we are being given the opportunity during these two days of meetings to discuss and debate almost all aspects of mandatory continuing education for members of the professions. We have been urged to consider what is the impact of mandatory continuing education on educational institutions, the professions, and staff development programs? What is its effectiveness and relationship to the quality of professional services? How should it be related to re-licensure and the policies of state regulatory agencies and federal agencies that are charged to protect the public welfare? Who should be the providers of continuing education and what systems of delivery should be supported? What methods should be employed for the assessment of needs and for the exercise of quality control over continuing education?

The answers to these and other questions cannot be satisfactorily developed by the representatives of only a few of the many interests concerned with the issue of mandatory continuing education. Fortunately the University of Illinois considered it appropriate not only to convene this conference but also to include individuals from a variety of backgrounds, professional schools and other providers, educators and consumers, federal legislative staff members and state legislators, and respreentatives of a number of the professions, such as allied health, dentistry, education, engineering, law, medicine, nursing, and pharmacy.

Since I have been invited to speak of the roles and responsibilities of professional associations, I am especially grateful that representatives of many of the professions are present. All of them may not initially fully agree with all of my observations and conclusions, which are somewhat at variance with the traditional concepts of the prerogatives of a profession and its assumed place in our contemporary social structure.

Traditional Concepts of a Profession

In any essay, which I have recently written at the request of the Council on Postsecondary Accreditation and which is entitled "Accreditation and the Public Interest," I have noted -

> . . . the traditional concept of a profession is based on the assumption that there is an esoteric body of knowledge that only members of the profession can transmit, that only they are capable of judging who should be educated and admitted to practice the professions, and that they solely should establish the ethics by which their members should practice and on which they should judge and discipline fellow members. Based on this concept the symbols of a profession have generally included the following characteristics that the professions insist are necessary attributes in order that they may maintain their autonomy and best serve the public interest, as well as incidentally the interests of their own members: (1) recruitment must be strictly controlled; (2) entrance must be strictly in the hands of the profession; (3) approval and accreditation must be done by the members of the profession; and (4) since recruitment, training and entrance into practice are all carefully controlled, any member of the professional group can be thought of as fully competent to supply the professional services.

Consistent with this traditional concept of a profession is the principle that each profession should have sole responsibility for disciplining and expelling its incompetent members. Therefore, if continuing education is offered, the profession should be the final judge of the content of the offerings; and if continuing education should be mandatory, the profession should be empowered to exercise the mandate. This philosophy has not been undermined by the powers of state licensure boards since these regulatory bodies have historically been comprised almost exclusively, if not entirely, of members of the respective profession, who speak of them possessively and, in the past, accurately, as "our board."

However, it is now being recognized more widely that state licensure boards are governmental agencies created and empowered to represent and provide for the interests of the public welfare and that their composition and policies have not always provided for the best interests of the public. At the same time as more attention is being given to these factors we are confronted with problems related to mandatory continuing education and the transcendentally important issue of social control of the professions.

Factors Making Continuing Education Essential for the Professions

A number of factors have stimulated the professions to exercise their traditional concern for the continued education of their fellow members. All professions have been affected by the proliferation of scientific discoveries and the resultant technological advances which have made much past knowledge obsolete within a short period of time. For example, the multiplicity of drugs with their diverse side-affects and the rapid replacement of some older forms of treatment by newer methods require that not merely physicians but all health workers must constantly continue their education in one form or another.

Again with reference to the health fields, it must be noted that specialization has in turn fostered the advent of a large number of related professions. In the field of radiology, for example, we now have such vocational classifications as radiation physicist, radiobiologist, radiologic technologist assistant, radiologist administrator, radiologist assistant, radiology aide, and x-ray equipment repair technician. Most of these newer vocations have their own regional and national associations that aspire to professional status. For such recognition they endeavor to adopt the previously identified traditional characteristics of the more esteemed professions of law and medicine.

To incorporate intothe health care delivery system these more recent professions and health vocations, as well as the expertise that these professions are prepared to provide, new and revised settings for the delivery of health care have had to be devised. In addition, the importance of health team involvement has had to be inculcated among the wide diversity of health workers who now nationally number over five million persons. The traditional health care system based on an individual, entrepreneurial approach is gradually being displaced and the replacement by newer patterns is further necessitating continuing education.

Underlying all of these factors are several other influences that support the concerns of the professions for the competence and the needs for continued education of their members. It is undeniable that all professions are both theoretically and actually committed to providing the best professional service to the public. However, at the same time the professional societies must be committed to protection of the economic and political welfare of their members. Otherwise the societies will not long exist.

Sponsorship and support for continuing education does provide some measure of protection from the increasing number of liability law suits, and it also provides some protection to the profession from incursion by other professions into its sphere of presumed professional jurisdiction. These factors, which are related to professional protection, now so important in our contemporary society, undermine continued acceptance of the traditional concepts of a profession on the basis of which it has exercised the prerogatave singly to develop its own code of ethics, to judge the continued competence of its members, to discipline and, if necessary, expel them from membership or restrict their privileges to practice, and also to exercise control of mandatory continuing education.

Factors Altering Control of Continuing Education by a Profession

Traditional concern of the professions for the continued competence of their members and rapidly developing attention to the economic, political and professional welfare of these same members create a conflict of interests for the professional societies. Public recognition of these conflicts of interest has been stimulated by several different factors.

Strikes, sit-ins, slow-downs and unionization, once anathema to any professional person, are now being employed by many different professions to gain increased economic benefits, improved working conditions, and extended fields of jurisdiction. Concurrently, all professions are making greater recourse to all three branches of both the federal and state governments to seek support for their respective goals. In so doing they are further eroding traditional concepts of independence and autonomy for professions, and they are encountering unaccustomed reactions as they enter the political arena.

Women, who have generally been hindered in the past in gaining entrance to the more revered professions, and various minority groups, who have encountered similar difficulties, are exerting political pressures for changes in control exercised by the professions. Furthermore, the public is disenchanted with rapidly rising fees for professional services provided by individuals whose education has in most cases been subsidized by public funds; namely, taxes. Part of this backlash has undoubtedly been demonstrated by some jury decisions for exceedingly large financial awards in liability suits.

A final factor to be mentioned relates to the facts that professional services are now more frequently provided in organizational settings and professional services are becoming increasingly specialized. Under these conditions jurisdictional issues grow more acute.

Professional conflicts require resolution. However, since many such conflicts cannot or, at least, are not being resolved by the parties directly involved, they are either being allowed in some cases to fester and inflame inter-professional feelings and attitudes and retard delivery of good services, or they are being settled by the participation of outside interests. This point leads to the issue of the place of the profession in mandatory continuing education.

Continuing education is related to continuing competence, and continuing professional competence is related to the ability of the practitioner to provide service to the public, and the service that is provided relates to the field of jurisdiction in which that profession is expected to perform. These are issues of direct concern to each profession, but they also are issues that society can no longer afford to delegate to any profession singly to decide and resolve.

It should be noted that I have stated continuing education is related to continuing competence; however, I did not state that continuing education guarentees continuing competence. Also, I have stated that continuing professional competence is related to the ability of the practitioner to provide service to the public, but I did not state that continuing professional competence guarantees service to the public.

On the other hand, I have implied rather directly that continuing education for any profession does have an immediate bearing on the extent of jurisdiction of practice, and fields of jurisdiction are issues of conflict between and among professions. The public has a direct concern for the resolution of these issues. This factor is closely inter-related with the subject of this talk; namely, what are the roles and responsibilities of professional associations in professional standards, competence, and continuing education?

Alternative Roles of Professional Associations in Continuing Education

Under economic, political and social conditions, both contemporary and anticipated, there appear to be only three alternative roles for a professional association to pursue with regard to professional standards, competence, and continuing education.

The first alternative would be for a profession to strive to retain, in the case of the older professions, or to obtain, in the case of the recently identified professions, control over these activities and functions. As indicated earlier, this approach involves a direct conflict of interest between the inevitable economic, political, and professional goals of the members of a profession and the professions's commitment and stated intent of primacy of service to the public welfare. The dependence of society on continued and constructive performance of the professions and the major and growing amount of funding from government and third-party payers in the health fields, and now emerging in the legal area, have created a situation in which a profession is no longer being permitted unilateral power of decision in issues of professional standards, competence, and continuing education. Many members of professions will react in opposition to this observation but their protests will not alter the facts.

A second alternative is for professional standards to be established by governmental regulation and legislation with only a minor contribution from the professions themselves. It is this possible development against which one hears much berating and protesting. Each of you at this conference has undoubtedly listened to more than one impassioned speech at meetings of your own regional and national associations to the effect that your association should and will continue to maintain control and that no external body, governmental or nongovernmental, will ever be permitted by your association to dictate what your standards of practice will be. You have also undoubtedly heard at these same meetings declamations that your associations will retain control over the standards of those professions which provide services subject to your supervision, and that this control is necessary for the maintenance of quality of service to be provided to the public.

Such expressions of chauvinism provide an emotional outlet for those who have not mastered the art of compromise and who do not appreciate that success of government in a democratic society is dependent on constructive compromise. Unalterable opposition to constructive compromise can frequently lead to loss of the very objective the uncompromising individuals are fighting so intently to retain. Simple objection to government and public involvement in the establishment and maintenance of professional standards and competence, including continuing education, will more likely lead to an eventual reduction in professional influence to such an extent that not merely the professions but society would suffer.

The third alternative for the role of professional associations in continuing education is that of shared responsibility. This approach is difficult for professions to accept and to practice, especially the older ones that have thrived on autonomy and a presumption that their infallibility can be questioned adequately only by members of their own profession. They have not been trained for negotiations, and certainly not in regard to matters in which they have assumed that they were sovereign; for example, the establishment and enforcement of standards for the continuing competence of their members.

Despite difficulties in the development of patterns of interprofessional cooperation and despite resistence to inclusion of individuals from professions, government officials, and representatives of the general public on boards, commissions, and committees charged with such responsibilities as statements of ethics, professional standards, and continuing education, such a broadening of involvement is the direction in which the professions must be moving. Fortunately, a few professions already have recognized the advisability of introducing and adopting such changes. I anticipate that others will relatively rapidly begin to follow their pattern.

Reasons for Shared Responsbility in Continuing Education

As we approach the conclusion of this presentation, we might remember theadmonition of the white rabbit to Alice -- which way we walk depends on where we want to get to! We should ask ourselves, where do we want to get to?

There are several desiderata with respect to professional services for our society. First, we wish to have access to professional services provided by qualified personnel, and also be guaranteed reasonable assurance of the continuing competence of this personnel. Second, we wish members of the different professions and related vocations to cooperate enthusiastically, fully, and on a reciprocal basis with members of other professions in providing these services. Third, we wish members of the professions to be compensated for their services in a reasonable manner and on a just basis. And fourth, we wish the professions and their members to participate in the establishment and maintenance of standards in education and in service, but in such a manner and to such an extent that there is an absolute minimum of conflict of interests.

In addition to these four factors there is a fifth element, one that is of fundamental importance to the conduct of our democratic form of government, the continued success fo which depends on a balance of forces among several vital entities. These forces include the three branches of government: executive, judicial, and legislative. The balance of forces also includes the federal, state, and local governments. A further requisite ingredient is a functioning balance between the civil government and the private sector of our society. For the private sector to be a vibrant force it must rely to a large extent on associations and organizations with leaders who believe in and have mastered the art of cooperation among themselves and who are demonstrably committed to placing the welfare of society foremost. Collectively the professions can play a significant part continually to re-strengthen the private sector of our body politic so that the private sector serves as a positive, constructive force within our total democratic society.

Sharing responsibility for professional standards, competence, and continuing education provides more assurance of attaining each of these five social goals than for a profession alone to assume the responsibility or for government to do so. But such sharing is not easy to implement. In addition to some revisions in attitudes on the part of members of the many professions, it requires involvement of individuals with diverse backgrounds and interests.

In confronting issues related to continuing education we must have the active participation of members of the professions, practitioners and educators, regulators and individuals from related professions, test construction experts and providers of continuing education offerings, as well as competent public members.

This conference sponsored by the University of Illinois provides an excellent opportunity for representatives of each of these groups to participate in a collective and cooperative review of the issues related to mandatory continuing professional education. It also provides me with the opportunity to conclude with a cautionary comment.

Beware of False Hopes!

"Oh dear! Oh dear! I shall be too late!" These were the words which Alice over-heard the white rabbit utter and which encouraged her to follow him down the rabbit-hole into wonderland. I have been wondering for some months if the ardent advocates of mandatory continuing education may also have shared the vision of the white rabbit and feared that they likewise might be too late.

The rush to mandatory continuing professional education is based on the premise that society must be assured of continuing competence of those who are providing professional services, and that participation in continuing education provides reasonable assurance of such competence; otherwise, why should it be mandatory? But there is no such assurance that has yet been proven valid. For most professions we have been unable to define in measurable terms what is continuing competence, nor have we as yet developed the tools and techniques for such measurement of competence.

In the process of mandating continuing education we are spawning a large number of providers who are beginning to develop their vested interests and political clout and for whom accrediting procedures are being devised; these will require a bureaucracy and extensive volunteer efforts to operate, plus much financial support. Furthermore, we are not assured that the accrediting techniques developed to date are adequate for the extremely wide diversity of continuing education programs being offered and being proposed in disparate settings. What we seem to be doing is shoring a vessel out of water that may be filled with false hopes at this stage in the development of testing, measuring and identifying professional continuing competence.

Continuing professional education we should have, and we should ardently support it and strongly encourage members of all professions to pursue it. But making continuing education mandatory without assurance of its validity for continuing competence may be like following Alice into wonderland where things are not what they seem.

THE IMPACT OF MANDATORY CONTINUING EDUCATION REQUIREMENTS ON PROFESSIONAL ASSOCIATIONS

William J. Greek, D.D.S.
Executive Director
Illinois Dental Society

Within the last ten years there has been a groundswell of interest in continuing education from public officials, both elected and appointed. Legislative commissions have been formed to hear testimony and make recommendations to their parent bodies. People in executive positions have issued press releases chastising, if not condemning, professionals; and consumer advocacy groups have been no less reticent about their concern for continuing education for providers of services. The purpose of our workshop group is to determine what, if any, impact mandatory continuing education will have upon professional associations. It is my task, not only to work with you in arriving at conclusions on our assignment, but to briefly address the question from the viewpoint of this observer.

At the outset, allow me the prerogative of stating some of my own biases, since I wish to be completely open with you as we begin our assignment. For a number of years I have taken exception to the use of the phrase "continuing education" preferring to use "continuing study" as an appropriate alternative. Education by definition connotes an acquisition of knowledge from which a change in behavior occurs. To suggest that an exposure to information or recent discoveries will result in altered treatment or service patterns is to ignore most of the data extant about professionals, or for that matter, homo sapiens in general. I do not discount the value of well informed professionals, nor do I admonish any diminution of lectures, demonstrations or seminars - on the contrary, there should be many more and they should be better attended. But, to suggest that attendance results in education is to overlook all basic educational testing machanisms.

There are those who also espouse challenge examinations of professionals for relicensure suggesting that these would ensure that professional personnel are receiving education after completing their basic graduating requirements. This approach from an educational standpoint is also fallacious from the viewpoint of this observer. At best we would pretest the candidates, expose them to information, and then post-test them to see if the information was received. To test a postgraduate health professional along the lines suggested would be merely achievement testing and hardly designed to measure the educational process. Allow me to cite an illustration of the case in point. If a dentist were to be pretested, exposed to information, and post-tested for achievement, how can we be assured that the knowledge acquired resulted in an alteration in a treatment procedure?

The various professional societies have long been involved in supporting continuing study - in fact, that is the primary reason for their existence. To suggest that this concept is a recent innovation is to overlook the fact that many professional organizations have been conducting scientific and clinical sessions for over one-hundred years.

The Illinois State Dental Society, with its components at the local level, are responsible for over three hundred meetings each year in Illinois. Coupled with this effort are the specialty groups and the four dental schools; so one should not be misled into thinking that continuing study courses are not available for dentists. The problem with many of these courses had been the setting and locale in which the scientific programs had been presented, as well as encouraging the profession to attend. As a result, we instituted a Continuing Study Subsidy Program in 1968 which has been highly successful and rewarding. Each year, twelve hours of programming are supported by a subsidy grant and conducted at the local level throughout the state. The local societies determine their areas of interest and secure the clinicians for two, separate, six hour courses of instruction; one of which is conducted in the fall and the second in the spring. In this manner we have initiated what might be termed a "University without Walls" and have attracted over 80% of our membership during the period that our program has been conducted.

It is not my intent to make laudatory comments about the profession I represent, but rather to draw a comparison with other professional organizations. The Dental Society has almost 6,000 members who, through a relatively substantial dues structure, can support programs such as have been described. This observer is concerned with a mandatory approach to continuing study since smaller associations will not be financially able to support such programs. For example, we have expended almost $200,000 in the subsidy program alone, in addition to the regular monthly meetings of each local society and the annual session of the State Society. Additionally, the staff time and logistics surrounding such programming is of considerable magnitude and could be overwhelming to many of the smaller associations. I am also concerned with that practitioner who might voluntarily retire rather than submit to a standard which was established without his cognizance nor support.

Our task then, is to attempt to delineate the problems which professional associations will face if, and when, mandatory continuing study becomes a reality. Might I suggest to you that what we are all talking about is an end result of an educational experience. We are not discussing so much mandatory continuing study or education. We are not discussing challenge examinations for relicensure. We are talking about continued competency of licensed individuals to provide professional services to those seeking those services. It is therefore incumbent upon all professional associations to look at the total picture of continued competency and the steps necessary to reach that goal.

Notes on the workshop session, "Impact of Mandatory Continuing Education Requirements on Professional Associations"

The consensus of the group was that mandatory continuing education was clearly the direction that the professions were going. The central question raised was: what can the professional associations do, and what role could/should they play in that process.

Because of the sense, "if we don't do it, someone will do it for us," it is obvious that mandatory requirements should evolve from within the professional association. It should establish minimum standards; identify competencies; develop self-directed study material; and set performance capabilities that general practitioners should have. The professional association should clearly make the decisions on what the guidelines of continuing education should be.

The professional association should create the market for continuing education, and be responsible for what happens to the professional after career entry, and assure competence of the professionals in their field.

Some questions and observations raised at the workshop were:

-- What can a professional association do when people join in order to obtain certification, then drop out? One response to this dilemma was to certify for a number of years only, requiring membership in the association for relicensure or recertification.

-- The concern of many was that continuing education is not now linked to competency. Mandatory continuing education does not deal with this issue at all.

-- A representative from one profession observed that those persons up for recertification were mainly concerned with whether or not the course content would help them pass tests. There is a critical concern for good methodology on the part of the association and participants.

-- There is a need for uniformity of standards for continuing education requirements, because many practitioners are licensed to practice in several states.

-- How will mandatory continuing education deal with the issue of someone who is licensed by the state and certified by the association?

-- The importance of relevant, problem-centered courses, rather than subject-centered courses was stressed. It was felt that mandatory requirements should be applied in content, rather than theoretical.

-- The need for educators to work with the professional association in planning educational activities was seen as a crucial ingredient for successful activities.

-- A "competence assurance program" for medical technologists was described by the educational consultant to the association. A list of 500 measurable skills has been identified, which will be received by the membership of the professional association. They are in the process of identifying assessment instruments and setting up programs for specific competencies. The program uses the principle of success by approximation, and is a self-study program.

Notes complied by Linda K. Bock

AN ALTERNATIVE TO MANDATORY CONTINUING EDUCATION: THE AMA PHYSICIAN'S RECOGNITION AWARD

Clarke W. Mangun, Jr.
American Medical Association

INTRODUCTION:

The practice of a profession requires a lifetime of learning. Until the 1920s, most of the learning physicians did after acquiring an MD degree was devoted to improving their skills and judgment. During the 1930s, new and useful knowledge in all areas of medicine began expanding at an exponential rate.

THE PHYSICIAN'S RECOGNITION AWARD (PRA) OF THE AMA

The PRA of the AMA was established in 1968. The most important objective was to commend and encourage physicians to carry out a personal program of continuing medical education. The basic criteria for the Award, however, were modeled after the continuing education membership requirement of the American Academy of Family Physicians. The Academy had demonstrated the feasibility of a continuing medical education requirement for more than 20 years before the AMA established the PRA for all physicians.

The Award was first offered in 1969 and required 150 hours of participation, called a credit hour, over a 3-year period of time. Table 1 (p. 78) contains a tabulation of the number of physicians who have qualified for the Award each year and the number who held a valid Award each year. You will notice that there is a gradual decline of qualifying physicians during the first three years and then a progressive increase as physicians requalify for the Award and additional physicians qualify for the first time.

Table 2 (p. 79) describes the criteria for the 1975 Physician's Recognition Award. You will notice that there are credit hour limits for all of the categories, except Category 1. Instead of a limitation, there is a requirement that at least 60 credit hours, of the 150 required for the Award, must be in Category 1. Physicians are encouraged to acquire all of the credit hours required for the Award in Category 1. (See Table 3, p. 80) Category 1 requires that the program be sponsored or cosponsored by an organization which is accredited for continuing medical education by the Council on Mecical Education of the American Medical Association and that the continuing medical education activity meet the definition of a planned program of continuing medical education. Tables 4 and 5 (pp 81 and 82) display the definitions which are used for accredited sponsorship and a planned program of continuing medical education.

Medical organizations, such as medical schools, medical professional societies, hospitals, etc., may apply to the American Medical Association for accreditation for continuing medical education. Accreditation for continuing medical education is a separate and distinct process from approval of a medical school or approval of an intern or residency training program. Through a cooperative program with state medical associations, there are now approximately 800 organizations accredited for continuing medical education in the United States.

Thus, only an accredited organization may certify that one of the continuing medical education activities it sponsors or cosponsors meets the criteria for a specific number of hours for Category 1. The accredited institution uses a standard announcement as its certification.

Thus, by holding accredited organizations responsible for the quality of the programs they produce and certify for Category 1, there is an assurance for quality of a substantial proportion of the credit hours a physician must earn for qualifying for the Award.

Returning to the listing of criteria for the Award (Table 2, p. 79), Categories 2 through 5 are designed to give limited recognition to many other ways that physicians and organizations accomplish continuing medical education. Category 2 provides for continuing medical education activities which do not meet both of the criteria for Category 1. Category 3 recognizes the value of the continuing medical education that is demanded when a physician teaches. Category 4 gives credit for the continuing medical education value of preparing a publication, presentation or a scientific exhibit. Category 5 gives credit for the educational value of continuing medical education activities physicians do themselves without formal supervision and includes such things as the use of audiovisual materials, the consultation he may receive from a medical teacher or consultant, activities dealing with the review of patient care, participation in a self-assessment examination, and preparing for the examination of a medical specialty board. Category 6 is designed to give credit for meritorious learning continuing medical education activities which do not seem appropriate for any of other categories. In applying for credit in Category 6, a series of questions is suggested so the answers to the questions will give sufficient information that the educational worth of the activity can be evaluated and an appropriate number of credit hours granted.

Although it is somewhat complicated, there are additional criteria for Category 1 which are used for audiovisual materials. The purpose of these additional criteria is to assure the educational quality of the materials and to assure that they were used appropriately.

TRENDS AGAINST VOLUNTARY CONTINUING MEDICAL EDUCATION

The policy statement of the American Medical Association on continuing medical education urges voluntary participation. The Award is voluntary and open to all physicians, allopathic as well as osteopathic, in the United States. Membership in the American Medical Association or any other medical organization is not required in order to qualify for the Award or receive the Award certificate. There is, however, an application fee of $25.00 for physicians who are not members of the American Medical Association.

Although the practice of a profession requires a lifetime of learning, there are strong and effective social, medical and economic pressures to require a lifetime of learning from physicians. State boards of medical examiners have legal responsinility for the quality of the professional services given by physicians whom they license. On Table 6 (p. 83) is a listing of state boards of medical examiners whose state laws provide continuing medical education as a requirement for re-registration of the license to practice medicine. Those designated by an asterisk have laws which mandate the board to require continuing medical education. Those states not so designated have permissive legislation which authorizes the board to require continuing medical education as a condition for re-registering the license to practice medicine if they choose to do so. On Table 7 (p. 84) are listed state medical associations which have adopted a policy to require continuing medical education as a condition of membership. Though all have adopted the policy, most of them have not yet established their criteria and implemented the requirement. On Table 8 (p. 85) are the medical specialty societies which have adopted a policy of requiring continuing medical education as a condition of membership.

Among the 22 medical specialty boards which certify physicians as specialists, all 22 have adopted the policy advocating recertification at specified intervals. Although most of the specialty boards are now developing their criteria and procedures for recertification, it seems likely that continuing medical education will be required, or strongly encouraged, as a part of the recertification process.

THE RELATIONSHIP OF THE PHYSICIAN'S RECOGNITION AWARD TO OTHER PROGRAMS WHICH CERTIFY PHYSICIAN PARTICIPATION IN CONTINUING MEDICAL EDUCATION

From the listing of organizations we have reviewed which have adopted policies that would have the effect of requiring continuing medical education, most of them have not established criteria for the requirement or implemented the requirement. In its role as a professional medical organization to all of the medical profession, the American Medical Association offers to serve as a central resource to individual physicians and medical organizations in reviewing and evaluating applications for certification in continuing medical education. As an example, the Department of Continuing Medical Education of the American Medical Association reviews the applications for the continuing medical education certificate for the specialty of Pathology and for the Arizona Medical Assoication certificate for continuing medical education. These programs are arranged so physicians qualifying for these certificates also qualify for the American Medical Association Physician's Recognition Award. It is anticipated that the AMA will continue to expand this service to individual physicians and medical organizations.

THE FUTURE OF VOLUNTARY CONTINUING MEDICAL EDUCATION CERTIFICATION

While the continuing medical education certification program of the California Medical Association and the Physician's Recognition Award program are two large, well developed programs that are voluntary, secondary use of these programs by other organizations seem likely to limit the voluntary aspect. For example, recently enacted federal legislation provides an annual bonus of $500.00 to certain physicians employed by the Veterans Administration if they have a valid Physician's Recognition Award. The implementation of this legislation produced a marked increase in voluntarism among Veterans Administration physicians.

FUTURE TRENDS

The Physician's Recognition Award is an evolving program. As techniques become available, efforts will be made to relate the Award to continuing medcial education interests and needs of physicians and measure the effectiveness in terms of improved patient outcome of the educational programs the physician used in order to qualify for the Award.

AMERICAN MEDICAL ASSOCIATION PHYSICIAN'S RECOGNITION AWARD

* AWARD YEAR	NUMBER OF PHYSICIANS QUALIFYING	NUMBER OF PHYSICIANS WITH A VALID AWARD
1969-1970	14,795	14,795
1970-1971	8,822	23,617
1971-1972	5,450	29,067
1972-1973	11,498	25,770
1973-1974	12,448	29,396
1974-1975	16,798	40,744

July 1 through June 30

Table 1

Criteria for the AMA Physician's Recognition Award. 150 credit hours over a 3-year period, of which, 60 must be in Category 1.

Category		Credit Hour Limit
1.	CME Activities with Accredited Sponsorship	No Limit
2.	CME Activities with Non-ACCREDITED Sponsorship	45 Hours
3.	Medical Teaching	45 Hours
4.	Papers, Publications, Books, and Exhibits	40 Hours
5.	Non-supervised Individual CME	45 Hours
6.	Other Meritorious Learning Experiences	45 Hours

Table 2

CRITERIA FOR CATEGORY 1 FOR THE PHYSICIAN'S RECOGNITION AWARD

1. The CME activity must be sponsored or cosponsored by an organization accredited for CME by the Conucil on Medical Education
2. The CME activity must fulfill the requirements of a planned program of CME.

CME - (Continuing Medical Education)

January 1, 1976

Table 3

ACCREDITED SPONSORSHIP OR COSPONSORSHIP

In sponsoring or cosponsoring a CME program, an accredited organization must be sufficiently involved in the planning, development, administration and evaluation of the program to assure that it meets the definition of a planned program of CME, and must accept full responsibility for its educational value.

January 1, 1976

Table 4

DEFINITION OF A PLANNED PROGRAM OF CONTINUING MEDICAL EDUCATION

For the purposes of the Award, a planned program of CME is one having sufficient scope and depth of coverage to form an educational unit that is planned, coordinated, administered and evaluated in terms of a specific educational objective, such as a defined level of knowledge or a specific performance skill to be attained by the physician participating in the program.

January 1, 1976

Table 5

STATE BOARDS OF MEDICAL EXAMINERS WHO HAVE AUTHORITY TO REQUIRE CME AS A CONDITION FOR RE-REGISTERING A LICENSE TO PRACTICE MEDICINE

Illinois +
Kansas
Kentucky
Maryland +
Michigan +
New Mexico +
Ohio
Washington +
Wisconsin

+ Mandatory

January 1, 1976

Table 6

STATE MEDICAL ASSOCIATIONS WHO HAVE MADE A POLICY DECISION TO REQUIRE CONTINUING MEDICAL EDUCATION (CME) AS A CONDITION OF MEMBERSHIP, BUT NOT ALL OF WHOM HAVE BEEN ABLE TO IMPLEMENT THIS DECISION AS OF JANUARY 1, 1976:

Alabama
Arizona
Florida
Kansas
Maine
Massachusetts
Minnesota
Montana
New Jersey
New York
North Carolina
Oregon
Pennsylvania
Vermont

Table 7

MEDICAL SPECIALTY SOCIETIES WHO HAVE MADE A POLICY DECISION TO REQUIRE CME AS A CONDITION TO MEMBERSHIP, BUT NOT ALL OF WHOM HAVE BEEN ABLE TO IMPLEMENT THIS DECISION AS OF JANUARY 1, 1976:

American Academy of Family Physicians
American College of Emergency Physicians
American College of Radiology
American Psychiatric Association
American Society of Abdominal Surgeons
American Society of Plastic & Reconstructive Surgeons, Inc.

Table 8

ACCREDITATION OF CONTINUING EDUCATION PROGRAMS FOR PROFESSIONALS

Jeanne Burson, PhD
Ohio State University

During this session I will, state assumptions and identify purposes of continuing education (CE) for health professionals; describe a process for approving programs; and allow group interaction to: 1) discuss problems of program accreditation in mandatory CE; and 2) effect possible alternative resolutions to the problems.

Given a brief overview of a procedure for approving CE programs for health professionals, the participant, as a member of a group, should be able to: 1) identify problems that might be encountered in approving programs for mandatory CE; and 2) offer suggestions for resolution of the problems.

Rational for Continuing Education

In many articles, books, papers or proposals written about CE, the same idea appears, in some form, concerning the rationale for CE of professionals. In essence it is: rapid technological progress, sophistication of procedures, complexity of equipment, and the growing demand for accountability in regards to health care, makes it imperative that professionals keep current with developments in their area of expertise. Therefore, the training process, responding to contemporary pressures for professional competence, must continue throughout an individuals productive life.

However, there is considerable evidence of the failure of CE programs in the health professions, especially in mandatory systems. Adults may be coerced into attendence but learning and subsequent application of knowledge may not be forced. Participation and ego involvement are basis underlying concepts in true adult education. Therefore, the type of program and the methods of instruction are all important, if the knowledge transfer is to be made and health care improved, through CE. Nevertheless, since accountability demands quantitative evidence, CE has been accepted as the easiest and most accessable method for documentation in evaluating accountability. This acceptance has created a need for a uniform method of accrediting and recording CE activities.

Definitions

Before we focus on the accrediting process--in a voluntary and mandatory system, we should identify what we mean by accrediting. Various definitions may be: 1) to confer acceptance on, 2) to approve of; 3) to vouch for as to conformity with a standard; or 4) to certify as fulfilling requirements. For some time professions have interpreted the process to mean worthy, proper, right; or to express a favorable opinion of, or to accept as satisfactory. However, with accountability, as previously mentioned, the interpretation is beginning to change to a more measurable definition--such as fulfilling requirements or in conformity with a standard.

Accreditation

One form of accreditation exists in credit CE activities (academic). How about non-credit activities? Since the work of the National Task Force on the Continuing Education Unit has been refined and tested, the criteria and guidelines are now being recognized as one basis for implementing the CEU as a uniform national standard of measurement for non-credit CE (12). The CEU is defined as ten contact hours of participation in an organized continuing education experience under responsible sponsorship, capable direction and qualified instruction. Each of the elements included in the definition is an integral part of the whole concept of developing an educational experience of sufficient merit to be documented in permanent form on the record of the individual participant. These elements may be applied equally regardless of the teaching-learning format, program duration, source of sponsorship, subject matter, level, audience or purpose.

As a basis for our discussion, let's examine how one professional association has implemented this concept--The Professional Acknowledgement for Continuing Education (P.A.C.E.) of the American Society for Medical Technology (ASMT). For a professional society such as ASMT to endeavor to become an accrediting body for CE programs, offered by friends in industry as well as by prestigious educational institutions, seemed presumptuously daring. Nevertheless, the P.A.C.E. planners decided at an early point that institutional (blanket) accreditation would be unsatisfactory, and rejected it in favor of program accreditation, and a system based on that of the national CEU.

P.A.C.E. approval signifies that each education program, in order to be approved for P.A.C.E. CEUs, must be individually reviewed by the ENTIRE P.A.C.E. Subcommittee. Therefore, all members are fully satisfied that the program is a) necessary; b) well planned; c) designed with properly stated participant objectives in mind, d) complete with evaluation component to ensure that participants have really learned something, and 3) presented by persons who are qualified to instruct that particular subject material. The type of facility in which the program is offered, the participant/faculty ratio and the participant/equipment ratio are also considered. It is not the policy of the committee to refuse accreditation of programs deficient in any of the above mentioned areas, but rather to offer constructive suggestions so that sponsors may upgrade the program offering to enable it to meet P.A.C.E. standards of quality and effectiveness.

The P.A.C.E. Program Approval Request form and the Guidelines which accompany it are the backbone of the administration of the P.A.C.E. Program. The Program Approval Request (PAR) form is designed to provide information to the Sub-committee for their review. The Guidelines contain vital information concerning P.A.C.E., instructions for properly filling out the PAR, suggestions and examples of behavioral objectives, and detailed information concerning the need for each requirement requested on the PAR. The Guidelines ask for the full name of the program sponsor who should be consulted regarding the application, the technical and computer title of the program, all dates and locations of the offering, the purpose of the program, its content description, and the format and methodology of instruction. The Guidelines further explain the purpose and need for specific behavioral objectives and offer guides for preparing them. The rationale behind the individual evaluation and program evaluation are explained, noting the relationship between the stated objectives and the evaluation of those objectives. A description of any laboratory activities, along with a detailed time schedule must be submitted. The time schedule, including breaks and laboratory activities, is used to calculate CEUs; therefore, it is critical that it be adequately detailed. A curriculum vitae for each instructor who participates in the program must accompany the PAR form. Additional information, such as the level of instruction and fees or tuitions, is also to be included. All of this information is required by the P.A.C.E. Sub-committee and must be on file in the ASMT Executive Office before a program can be approved.

The P.A.C.E. review mechanism includes the committee, five (with various backgrounds) appointed from the membership, and two Staff members. Briefly, the review procedure is that depicted on the chart, p. 89. The request forms are duplicated and sent to each Sub-committee member. If not approved, all Sub-committee comments (called in) are recorded and presented to the sponsor for consideration. If conformity is forthcoming, the program is approved (for a year), CEUs are assigned and a log sheet is issued. Any changes in the program or the instructional staff must be submitted to P.A.C.E. before the issuance of a log sheet for subsequent offerings.

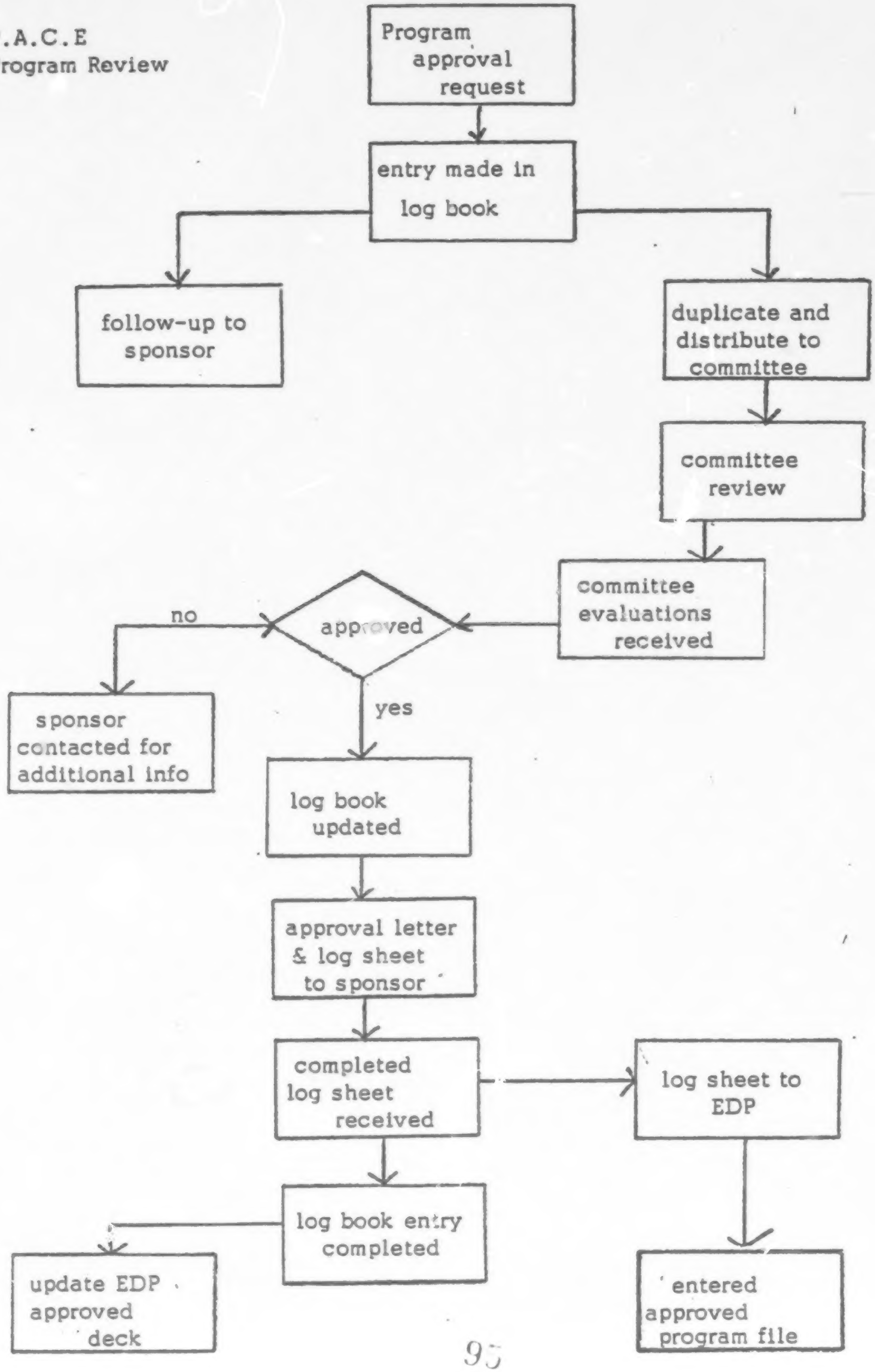
Effort is made to ensure the high quality of P.A.C.E. approved programs. In order to perform spot checks for program evaluation and P.A.C.E. accountability, program participants, randomly selected by computer, are sent questionnaires concerning a P.A.C.E. approved program they attended. They are asked if the objectives were met as stated, if an evaluation was given to meet the objectives, and whether or not the schedule was adhered to as stated. Also, auditors attend programs and report on whether the programs are properly represented in the PAR.

This process might be acceptable in a voluntary system--but what happens if CE becomes mandatory? Who should accredit programs? What type and how are programs going to be accredited (the plan and the activity) if professionals are to vouch as to the program's conformity with a standard, if the standard is expanded to include; essential or necessary to function--signifying continued competency and improved health care?

I have indicated that the type of program might make the difference between learning or not. By experience we know that an accreditation process that does not include in-house control or on-site activity evaluation, as to whether or not specifications are implemented and objectives are met, cannot itself be valid in a system attesting to participant continued competency. Who is to judge if a program is "right or necessary" for each individual participant.

So--are these really problems? What are others? What are some possible alternative resolutions to the problems? Let us see what we can generate in the time available. We sure can not solve the problems of the world, but maybe we can make the thought process easier if we are confronted with program accreditation and mandatory CE in the future. We may even 'come-up' with some good points that will apply to program accreditation today.

P.A.C.E
Program Review


Program approval request
entry made in log book
follow-up to sponsor
duplicate and distribute to committee
committee review
committee evaluations received
approved
no
yes
sponsor contacted for additional info
log book updated
approval letter & log sheet to sponsor
completed log sheet received
log sheet to EDP
log book entry completed
update EDP approved deck
entered approved program file

References

1. American Academy of Family Physicians, "AAFP Continuing Education Requirements", adopted 1973.

2. American Association for Clinical Chemistry. "Guidelines and Instructions for Programs requesting ACCENT Continuing Education Units (ACEUs)", draft 1975.

3. American Association for Respiratory Therapy. "PROCEED: The AART Continuing Education System", THE BULLETIN, September 1975.

4. American Nurses Association. "News" April 1975.

5. American Physical Therapy Association for Establishing Standards for Recording Continuing Education Units", December, 1974.

6. American Society for Medical Technology. ASMT NEWS. January 1976.

7. American Society of Clinical Pathologists. "Guidelines for ASCP cosponsorship of Regional Continuing Education Programs on an Annual Basis", 1975.

8. American Society of Radiologic Technologist. "Evidence of Continuing Education", 1975.

9. Gilford Instrument Laboratories, Inc. "Gilford Associates Program", 1975.

10. Libby, Maj. Glidden Neil, et al. "Help Stamp Out Mandatory Continuing Education!", JAMA, 233:7 August 18, 1975, 797-99.

11. Lindberg, David. "P.A.C.E.", CADENCE, 5:6 1974, 51-5.

12. The National Task Force on the Continuing Education Unit. "The Continuing Education Unit Criteria and Guidelines", Washington, D.C.: National University Extension Association, 1974.

"IMPACT OF MANDATORY CONTINUING EDUCATION ON A PROFESSIONAL SCHOOL"

Ruth I. Heinemann, M.Ed.
Director, Continuing Education
School of Associated Medical Sciences
University of Illinois at the Medical Center

Approximately 20 persons convened to discuss the topic "Impact on Mandatory Continuing Education on a Professional School". The Workshop Leader, Ruth I. Heinemann, opened the session by stating the workshop objectives prepared by the conference planners:

1. Examine the strain on resources created by mandatory continuing education;
2. Analyze its impact on the residential programs;
3. Discuss appropriate steps to insure capacity to deliver quality educational programs.

At Ms. Heinemann's suggestion, the participants formed two groups to discuss and prepare responses to four questions based onthe objectives. Each group appointed a recorder to compile and report the discussions. The questions and group responses are given below with additional ideas submitted by Ms. Heinemann.

Question #1: What resources does a professional school have for continuing education programs?

1. Faculty
2. Physical facilities such as classrooms, laboratories, meeting rooms, office space, parking space.
3. Audiovisual equipment such as:
    - cameras (35 mm, video, etc.)
    - projectors
    - blackboards
    - recorder/play back equipment
    - television
    - public address systems
    - computer consoles
4. Audiovisual materials
    - movie films
    - single concept films
    - slide/sound synchronized units
    - 45 mm transparencies
    - overhead projector film sets
    - library
    - periodical collections
    - cassette tapes
    - videotapes
    - self-directed study units
    - simulation models
    - computer programs

5. Technical equipment
6. Supply company and vendor contacts
7. Educational planning expertise
8. Clerical staff

Question #2: What is the strain on these resources?

1. Faculty
   a. Priority of planning/teaching in continuing education compared with priority of undergraduate/graduate needs.
   b. Readiness of faculty to work in formats and use methods of teaching other than lecture and supervising a laboratory.
   c. Faculty time commitment to continuing education as opposed to undergraduate/graduate education.
   d. Availability of replacement faculty or salary to enable released time for regular faculty to work in continuing education.
   e. Faculty members' understanding of factors affecting older adult's learning that may differ from young adult learning.
   f. Relationship of faculty members with their professional organizations.
   g. Faculty members' continuing education work priority in professional organization continuing education as opposed to school continuing education.
   h. Compensation of faculty for working in continuing education.
   i. Requirement for involvement in continuing education included in criteria for promotion and tenure.

2. Physical facilities
3. Audiovisual equipment
4. Audiovisual materials
5. Technical equipment
6. Clerical Staff

   The following comments apply to points 2 through 6:
   a. Priority of use for undergraduate and graduate students versus continuing education
   b. Generating and maintaining financial resources to procure and support this equipment and staff
   c. Departmental and campus priorities for continuing education that affect availability of services such as
      procuring and maintaining audiovisual equipment
      printing (duplicating)
      security (police)
      meeting rooms
      food service
      classroom/laboratory space utilization
      hotel accomodations
      mailing facilities
      recording system for attendance
   d. Generating financial resources to purchase audiovisual materials
   e. Competition between professional schools and professional organizations that creates a barrier to communications that could result in cooperation and callaboration.

7. Supply companies and vendors
    a. Company using its association with the School to enhance creditibility with customers
    b. School using company and vendor as source of free materials
    c. Cost of security to protect equipment against damage

8. Educational planning expertise
    a. Convincing faculty that continuing education must be planned as carefully as undergraduate/graduate courses and curriculum.

Question #3: What is the impact on the residential program? (undergraduate and graduate curricula)

1. Objectives of residential curriculum may be altered and/or augmented to provide for life-long learning concepts.
    (Comment at 2nd General Session that we seem to concentrate on skills competency rather than intellectual competence to read and apply to practical situations.)
    (Is this problem-solving skills?)
2. Provide for degree-completion in "non-traditional" mechanisms through continuing education offerings, proof of equivalence, proof of proficiency.
3. Orientation of undergraduate students to accept continuing education as a professional way of life.
4. Faculty development through preparation of continuing education programs and through participating in continuing education programs/activities.
5. Schools self-study (self-assessment) to determine their roles in continuing education could yield recommendations for making residential programs more effective and efficient through sharing materials, equipment, self-directed study development, etc. shared faculty.

Question #4: What appropriate steps can be taken to ensure capacity to deliver quality educational programs?

1. Criteria for quality must be prepared. (C.E.U.)
2. Criteria for priority must be prepared.
3. Collaborate with professional organizations and institutions.
4. Organize advisory committees representing the professional community.
5. Develop outlying centers for delivery of continuing education activities.
6. Develop service capabilities (printing, physical facilities, etc.)
7. Acquire or provide for financial resources to invest in continuing education.
8. Employ staff with full time responsibilities for continuing education program/activity development and services to coordinate faculty efforts.
9. Use participation in continuing education development and learning for criteria for promotion and tenure.
10. Develop faculty compensation system--some kind of a reward system for working in continuing as well as undergraduate and graduate continuing education.

The groups participated enthusiastically, concluding with an active reporting session that was constrained only by a lack of time to elaborate on these responses. Several commented that the format used permitted them to exchange ideas freely and profitably.

"THREE DECADES OF 'CONTINUING COMPETENCE' IN PHARMACY: AN INTERPRETIVE REVIEW"

Diane J. Fisher, R.Ph.
Marvin M. Weinstein, R.Ph.
College of Pharmacy
University of Illinois at the Medical Center, Chicago

INTRODUCTION

Continuing competence, particularly for the health professions, has come to the forefront of social awareness and public concern. Within the profession of pharmacy the purpose and nature of continuing competence has been analyzed, debated and evaluated over the past 3 decades.

In 1948, the Pharmaceutical Survey recognized the responsibility of the Colleges of Pharmacy in the area of continuing education. The survey served as an impetus for the establishment of continuing education courses by several schools of pharmacy. In 1955 the American Association of Colleges of Pharmacy (AACP) created a Committee of Continuation studies to study the methods by which the association could assist its member colleges in developing programs of continuation studies for pharmacists. The committee functioned until 1962 when a permanent section, the Conference of Teachers of Continuing Education, was established (1,2).

"Discussion and action on continuing education for practicing pharmacists had been confined mostly to the college and pharmacy board segments of the profession," until 1965, when the issue of continuing education was called to the attention of the entire profession at the annual meeting of the American Pharmaceutical Association (APhA) (3).

In 1967, pharmacists practicing in Florida and Kansas were subjected to mandatory C.E. requirements for license renewal (4-7). This legislative procedure touched off a great debate and it was said that "those who espouse the cause of voluntary acceptance of responsibility for maintenance of professional competency are going to be hardpressed to prove that the voluntary system has worked so far" (8).

The National Association of Boards of Pharmacy (NABP), the AACP, and APhA formed a tripartite committee on continuing education in 1970 to draw up guidelines to assist states in the development and administration of compulsary C.E. statutes (9). As a result, the NABP developed the Uniform Professional Continuing Education Act (10), and at its 1972 annual meeting endorsed the concept of mandatory C.E. as a requisite for extended licensure (18).

With the close of 1973, an additional 4 states had jumped on mandatory C.E. bandwagon and the controversy over continuing education mushroomed. Intensive study and analysis by the APhA Professional Affairs Committee in 1973-74 led to the realization that "the central issue facing the profession ... is the competence of all practitioners ... and that continuing education is only one means of maintaining professional competence, and must be viewed in the context of its role in lifelong learning" (11). The APhA adopted a policy strongly endorsing the concept of continuing education for pharmacists. However, "APhA feels the profession in each individual state should make its own decision whether or not to require continuing education consistent with nationally recognized standards if and when such standards are available" (12).

In accord with its C.E. policy, the APhA along with the AACP formed a Task Force on Continuing Competence in Pharmacy for the purpose of preparing a statement of basic principles and policies relating to the continued competence of pharmacists (13).

The Task Force (13) identified those contemporary factors which transform the maintenance of competency from a stagnant to an ongoing, lifelong process:

1.) the proliferation of scientific knowledge learning to the development of new drugs, new problems and new concepts;
2.) the technological advances which have freed pharmacists to provide expanded professional services to their patients and other health practitioners;
3.) the emergence of the 'health care team' approach to patient care;
4.) the emergence of government and private insurance programs;
5.) increased drug utilization which necessitates greater patient counseling and monitoring by the pharmacist;
6.) the emergence of multiple practice settings each making unique demands of the pharmacist;
7.) economic inflation which has stimulated the public to be more aware of the quality of health care services they receive;
8.) changes in legal standards which focus on the competency to practice;
9.) pharmacists recognition of their social and professional obligations to provide high quality health care.

The members of the Task Force advocated the development and support of pharmacy practice standards; that a valid means of assessing competence be devised; and that pharmacists be subject to relicensure at periodic intervals (13).

In assessing the report of the Task Force at its 1975 annual meeting, the APhA "adopted a policy supporting the voluntary approach to the maintenance of competence for the time being ... and by implication discouraged a stamped to relicensure legislation." (14).

The APhA and AACP have now launched the first phase of a joint competency project. A survey to be conducted during the summer of 1976 will attempt "to identify the specific behaviors which comprise pharmacists functions and provide an opportunity to 'uncover' and report additional facets of pharmacy practice" (15,16).

As attention was being focused on continuing competence, the issue of national accreditation standards emerged. States mandating continuing education began groping for a cure for the administrative chaos resulting from C.E. accreditation. It was also recognized that the assurance of C.E. quality was of paramount importance if it was to have impact on practitioner competence C.E. (17). In 1974 the ASCP, APhA and NABP formed a joint committee on accreditation in pharmacy "to initiate the process by which principles, standards, and procedures for continuing education accreditation may be developed for adaption for the profession" (18). It was the primary recommendation of this committee that the American Council on Pharmaceutical Education assume the accreditation responsibility. "In that role, the council will institute a process to assure pharmacists of the quality of continuing education offerings by evaluating the capability of the providers of C.E. programs" (19).

By February 1976, 13 states had enacted mandatory continuing education legislation; however, the vast majority of the country has opted for a voluntary approach to C.E. participation (4).

The past three decades are testimony to pharmacy's willingness to accept responsibility for the competency of its practitioners. However, societal forces continue to churn the emotions of those with vested interest.

Therefore, while national standards of pharmacy practice remain in an embryonic state, the profession must develop a long range strategy to bridge the divergent pathways leading to competent practitioners and quality pharmaceutical service.

PROPOSED PATHWAYS TO COMPETENCE

Competence has been defined as "the ability to accomplish an essential performance characteristic in a satisfactory manner" (20). "The Task Force on Continuing Competence in Pharmacy has identified two basic elements on which continuing competence in pharmacy depend: 1.) possession by the individual of a body of current up-to-date knowledge in the field of pharmacy, or in the specialty in which the individual practices and 2.) adequate and appropriate performance in a manner consistent with established professional knowledge and procedures. These two elements comprise both an ability and a desire on the part of the practitioner to provide good pharmaceutical services to his patients, and an environment that is favorable or conducive to such services" (13).

Various pathways have been advocated to assure competency. These include: 1.) participation in continuing education, both voluntary and as prerequisite to renewed licensure, 2.) periodic reexamination for license renewal, 3.) peer review.

PARTICIPATION IN CONTINUING EDUCATION

The AACP Guidelines for Continuing Pharmaceutical Education define continuing education as "all organized and directed educational activity beyond the period of formal education in which the goal is the continuous improvement in the vocational competency of the learner and the broadening of the spectrum of human understanding" (21).

A myriad of diverse purposes have been hypothesized to justify the involvement of practitioners in continuing education (9, 21-30). Analysis reveals that these purposes can be assigned to three categories (see Table 1) which parallel the cognitive, affective, and psychomotor domains (31, 32). Regardless of the factors motivating participation, if continuing education activities are to affect practitioner competence positively, then behavioral alteration in each domain is prerequisite (12). A knowledge base, though essential, is insufficient to trigger implementation in a practice setting. An appropriate attitude and sense of personal fulfillment, coupled with an adequate knowledge base, allows the professional to transcend into a higher level of practice. However, adequate knowledge and appropriate attitude do not guarantee that patient an optimal level of health care; and implementation void of appropriate knowledge or attitude can exert a degenerative effect.

In theory then, continuing education designed to cultivate cognitive, affective, and psychomotor outcomes can elevate the quality of pharmaceutical service.

VOLUNTARY C.E.

At this time, the practical effectiveness of voluntary continuing education as a method to achieve, maintain, or expand professional competence cannot be justly evaluated. Until national standards of professional practice are elucidated, continuing education planning will remain haphazard, and not necessarily harmonious with true practitioner needs (33-35).

Throughout its history, the planning of continuing education has often reflected the perceived needs of pharmacists usually defined by them as broad topic areas (e.g. Pharmacology, Hypertension, etc.). "All too often, faculty committees or individuals responsible for developing continuing education programs have relied upon a combination of intuitive feelings, preconceptions, and ingrained prejudices about what a pharmacist 'should' know to practice his profession, hence, what he 'should' learn in a continuing education activity" (36). The old and familiar soporific one-man stand-up monologues more often than not have been stamped from a template of the undergraduate curriculum (34, 37-39).

"From the inception of organized continuing education for pharmacists, typical programming has been focused on new product-oriented information and review of older product-oriented information" as opposed to patient-orientation (40). Program faculties have been heavily weighed with physicians, basic scientists and drug company affiliates whose role perspectives differ significantly from those of practicing pharmacists (34). And because of limited practitioner input in C.E. planning (41), programs have not always been directed toward meeting their needs in terms of improved pharmaceutical service and patient care. "Programs have ranged from comprehensive courses, intense in content to cruise trips and holidays .. programmed and festooned in ways which simply provide a thinly veiled means to enjoyment on the travel scene" (39).

Table 1: PRACTITIONER INVOLVEMENT IN C.E.

COGNITIVE DOMAIN	CHARACTERIZED BY THINKING -to acquire an updated information base required for responsible performance. -to master new concepts in relation to changing roles. -to keep pace with developments in the relevant basic disciplines. -to prepare for alterations in career plans.
AFFECTIVE DOMAIN	FOCUS ON DEVELOPMENT OF ATTITUDES, BELIEFS, AND VALUES -to improve one's attitude toward one's role and role functions. -to maintain a fresh outlook on daily activities. -to gain personal fulfillment and career enrichment. -to strengthen one's willingness to critically question ethical and scientific judgement.
PSYCHOMOTOR DOMAIN	FOCUS ON DEVELOPMENT OF MOTOR BEHAVIORS -to acquire the ability to perform new professional skills. -to improve one's ability to provide optimal pharmaceutical service qualitatively and quantitatively.

Evidence indicates that continuing education emanating from the Colleges of Pharmacy is quantitatively limited (3, 42, 43) which reflects a lack of funding, staff, and resources (21, 43-46). To date, the bulk of continuing education research by the colleges has concentrated on the collection of attitudinal and demographic data (1, 2, 47-57). Priorities in educational development of C.E. have centered around delivery systems, particularly mediated systems and self study packages which attempt to maximize practitioner accessibility and self directed study (58-84). Today, with these new delivery systems making C.E. more consumable and because more emphasis is being placed on clinically relevant role-related continuing educational experiences (54, 76), the commitment of pharmacists to voluntary C.E. is beginning to blossom (91).

The evaluation of continuing education may have been erratic and uncoordinated, however with identification of competencies and quality control standards, voluntary C.E. should prove to be a viable pathway to achieve, maintain, and expand professional competence.

MANDATORY C.E.

Mandatory continuing education as a means of assuring professional competence is a most controversial yet highly prescribed panacea (41). Mandating continuing education is advocated and justified on the basis of two fundamental assumptions: 1.) practicing pharmacists have not nor will not voluntarily accept the responsibility for their continuing competence (33, 34); 2.) exposure to the educational process guarantees continuing competence and the ultimate protection of the patient (86). Those advocates recognizing the frailties inherent in the second assumption rationalize via the following defenses: "While we recognize that mandatory C.E. is not the final word we do accept it as best alternative presently available" (87); and although the efficiency of learning may be low, "mandatory requirements at least get them (practitioners) out" (88).

Organized professional activities unequivocally demonstrate pharmacy's "forthright approach to the competency issue" (14). The level of participation in continuing education during its infancy is not a valid measure of individual commitment to competence. A lack of participation can be directly attributed to the erratic and uncoordinated evolution of C.E., its limited accessibility, and because past programs have "run the gamut from the ridiculous to the sublime" (88).

Assumption number two heralds inept expectations of educational exposure! In the words of Carl Rogers, "What is taught is what is learned; what is presented is what is assimilated. I know of no assumption so obviously untrue. One does not need research to provide evidence that this is false" (89). "Continuing education participation is a process and a means to an end, not an end in itself. The desired end is increased competence, performance, and service to society. Evidence that a professional engaged in the process, spent the time (and was awarded three CEU's) is not sufficient" (90). In fact, documentation is lacking to prove that the quality of health care can be improved by mandatory continuing education (35, 39, 91). In the state of Florida, one of the first to mandate C.E., the use of patient profiles, a recognized professional tool, remains relatively low (92). "An exhaustive literature survey by APhA staff has failed to uncover any conclusive evidence that participation in continuing education has produced an increase in the competence of participants" (11).

In subscribing to the letter of the law, the spirit of the law can be violated. Practitioners may be forced to fulfill requirements by enrolling in courses "which are either duplicative of competencies already possessed or irrelevant to their needs" (93).

Legislative mandates for continuing education require a reappropriation of educational resources whereby quality gives way to quantity (90). "Mandatory continuing education has in some areas been reduced to just another economic enterprise for providers who would seek to supply a commodity whose need has been justified to some solely on the basis of legislative edict in order to guarantee professional relicensure. All of this, like snake oil, can be purchased for a fee, tuition, or a tax write-off" (94).

When scrupulously formulated, continuing education can serve as a potent dosage form for the infusion of innovative concepts into the mainstream of pharmacy practice. Therefore, "the wholesale adoption of mandatory continuing education might have the unfortunate effect of freezing modes of practice at a time when concepts are on the horizon" (93).

PERIODIC REEXAMINATION

The Founding Fathers of the United States held the philosophy that the individual had an inherent right to choose and practice his profession without legal constraint. However legislation regulating the profession of pharmacy emerged (e.g. Illinois 1881) in answer to public outcry during an era of adulterated drugs and accidental poisonings (91). Thus, the purpose of licensure was to ensure the public competent practitioners and quality health care; and until recently, it was assumed that once having met the educational and legal requirements, the professional would remain competent thereafter.

Periodic reexamination for professional license renewal was proposed as a mechanism by which to assure practitioner competence and quality health care (13, 24, 49, 71, 95) when it became apparent that C.E. was just a means to an end.

The advocates of mandatory relicensure exams also hold the philosophy that pharmacists will not voluntarily accept the responsibility for their continuing competence. However, they add to this, the belief that examination can measure the level of competence, thus assuring the quality of health care (13).

With the advent of new evaluation techniques such as patient management problems and practice-oriented learning situations, behavioral objectives on all taxonomic levels can be measured within the cognitive domain. Laboratory simulations allow for evaluation of psychomotor outcomes. However, if competence depends on "up to date knowledge ... and adequate and appropriate performance" (13), as described by the Task Force on Continuing Competence, then, relicensure exams are not a reliable assessment of the quality of practice. An examination on a given day, in no way, guarantees that the practitioner will implement his abilities in a practice setting nor that the patient will ever reap the benefits of his professional expertise.

Evaluation instruments based on sound educational principles can, however, have a valid function. Rosinski suggested and the APhA has endorsed the concept of self-assessment techniques based on the professional practice standards, soon to be developed (14, 33, 96). Self-evaluation instruments would allow the individual practitioner to compare his abilities with those of his peers. They would enable the practitioner to identify his weaknesses and thereby direct his continuing education energies more appropriately. Self-assessment techniques could have a positive impact on practitioner motivation and C.E. participation; therefore self-assessment seems to be a more equitable approach (33) than mandatory relicensure exams which "would force new learning through a system of rewards and punishments" (49).

PEER REVIEW

'Peer review' is a generic term related to the philosophy that "health professionals are the most appropriate individuals to evaluate the quality of medical services" (97). Peer review can encompass either intra or interprofessional evaluation of the efficiency and quality of any aspect of health care delivery.

Peer review came to the national attention of pharmacy as a result of the 1972 PSRO legislation which established Professional Standards Review Organizations "to assure the medical necessity, appropriateness, and quality of medical care delivered to Medicare, Medicaid, and Maternal and Child Health patients" (98).

At its 1975 annual meeting, the APhA encouraged the profession, at all levels, to become actively involved in the development and implementation of PSRO review procedures (96, 97).

Educators have urged the profession of pharmacy to analyze peer review for its potential usefulness in assuring competence (24, 20).

However, to date, most discussion of peer review within pharmacy has been related to PSRO involvement (96, 99).

Other health professions have viewed peer review from a broader perspective (100 - 110). It has been suggested that the data obtained from peer review can be used by the individual to pinpoint his deficiencies, thereby providing direction for improvement (111). "This type of system allows an ongoing analysis of the performance of a practitioner. It precludes the sit-down, pressure-laden written examination, allowing the analysis of his performance on a day-to-day basis. This same basic philosophy eliminates the necessity for recertification of practicing physicians and should be considered very strongly in lieu of recertification examinations and/or any other type of in-practice examination" (112).

A PERSPECTIVE

The energies expended by the profession of pharmacy over the issues of continuing education and professional competence can now be harnessed and constructively utilized to formulate a perspective for future direction. If the profession is ever to reach its final destination: continuing competence; then the pathways, as presently proposed, must be rerouted, bridged and resurfaced.

The individual practitioner must accept the responsibility to remain professionally competent throughout his career. This thread of professional ethic must be meticulously woven into the fabric of collegiate experience (33). As a pre-professional, the student must be gradually immersed into the mainstream of life-long self-directed study. Student participation in continuing education can provide a fluid transition from pre to post-licensure and can eliminate the trauma of future shock.

The identification of practice standards must serve as a foundation upon which self-assessment mechanisms can be constructed under the guidance of instructional technologists at the Colleges of Pharmacy (113). Practitioners could then inventory their abilities, identify weaknesses, and select appropriate continuing education experiences.

Relevant C.E. experiences must then be plentifully available. This demands the academic development of a dual tract, integrated, and meaningful C.E. curriculum. A tract must be designed for individuals requiring an in-depth revitalization in the specific disciplines which comprise the academic foundations in modern pharmacy. And, a second tract must merge the underlying foundational disciplines into a comprehensive consideration of specific professional role-related functions (39). In order for this C.E. curriculum to yield fruitful outcomes, it must be internally innovative and must integrate academic content, a practice-oriented perspective, and the application of educational theory (114). Academic development draws on content channeled from a myriad of disciplines. A practice oriented perspective is of paramount importance to the success and general acceptance of any continuing education activity because it allows for the definition of content in terms of practice outcomes. "The application of educational theory helps process continuing education into a final meaningful experience and validates its usefulness to the practitioner" (114).

Most logically then, the bulk of continuing education development must emanate from the Colleges of Pharmacy. Within the colleges, C.E. developers must be innovative individuals who are themselves practitioners, academicians and educators. To be sure, basic scientists and non-pharmacist academicians must make important contributions to the continuing education efforts of the colleges, but it remains for the C.E. development faculty to steer the direction. Because the development of continuing education demands harmonious discourse within the profession itself, practitioners must be actively involved throughout the entire process from needs assessment through development, implementation and evaluation.

The Colleges of Pharmacy must also serve as educational consultants in order to assist local pharmacy associations in meeting the specialized needs of their memberships including: the identification and clarification of their perceived C.E. needs, the identification of alternatives in meeting group needs, the selection of the most appropriate educational resources, and the evaluation of the usefulness of their C.E. experiences.

In order for the colleges to fully develop and implement C.E. curriculum and make available their consultative expertise, continuing education activities must be subsidized by methods analogous to undergraduate education. The colleges' role in continuing education must be financially supported on the state and federal levels.

Voluntary continuing education fueled with practitioner motivation, accurate needs assessment, and a rich catalogue of relevant course offerings can trust the profession toward its destination. However, society must be guaranteed protection from those practitioners who shirk their responsibility to remain professionally competent.

Society has the potential to protect itself through the powers already vested in the professional licensing boards. To be most efficient, however, the state boards must adopt the professional practice standards which are being developed and use them to remove incompetent practitioners from the pharmacy manpower pool. But, the identification of alledgedly incompetent practitioners cannot be left to a handful of state inspectors with police power. This responsibility must be shared by the patient-consumer, by ancillary health professions, and by the profession itself.

Pharmacy must expand its consumer education efforts, so that all patient-consumers can effectively evaluate whether they are being provided with pharmaceutical services necessary for their health. Mechanisms must be established by which patient-consumers may channel complaints, questions, or evidence of substandard practice to the professional.

Ancillary health professionals must be encouraged to question professional judgments and to bring to the attention of the profession suspected cases of substandard practice.

The profession of pharmacy must provide the impetus for an organized system of ongoing professional review but in order for the system of professional review to attain maximal effectiveness it must be designed to:

1.) identify alledgedly incompetent practitioners, via the patient consumer, ancillary health professionals, and the profession itself;
2.) suggest corrective measures (e.g. C.E. experiences);
3.) encourage innovation by allowing innovative practitioners to justify their methods;
4.) encompass the entire profession; (it cannot be limited to specific practice settings or health care programs);
5.) protect the rights of society by monitoring suspect practitioners yet, at the same time, safeguard the rights of the individual practitioner; and
6.) bring resistant practitioners to the attention of their state licensing boards for possible punitive action.

National acceptance of professional review based on these principles can bridge the pathways of voluntary continuing education, self-assessment mechanisms, and the State Board of Pharmacy.

When coupled with a professional ethic developed during the initial undergraduate phase of life-long self-directed learning this integrated approach can insure society competent pharmacists and quality health care. Far too often societal forces dictate proximate solutions via legislative edict. However, the quality of health care is far too crucial a matter to be validated by the bureaucratic rubberstamp of hollow assurances. Society must demand more and pharmacy must continue to aspire the ultimate.

Bibliography

1.) Braucher, C. L., "A Comparative Analysis of Three Years of Continuing Education Activity," Am. J. Pharm. Ed., 34 (2), 234 (May 1970)

2.) Jobe, B. D., "Growth and Development of Continuing Education Offerings by Schools of Pharmacy," Am. J. Pharm. Ed., 32, 610 (1968)

3.) "APhA's New Chief Urges Association To Develop Its Own Continuing Education Program For All Pharmacists," Amer. Druggist, 11 (April 12, 1965)

4.) National Directory of Pharmacy Continuing Education, National Council on Pharmacy Continuing Edcuation, Chicago, Illinois (June, 1975)

5.) "Kansas Is First State To Make Continuing Education Mandatory," Amer. Druggist, 27 (May 8, 1967)

6.) Lemberger, M. A., "Preliminary Experience With Mandatory Continuing Education," JAPhA, NS13 (8), 409 (August, 1973)

7.) "Continuing Education Law is More Specific," Amer. Druggist, 24 (July 27, 1970)

8.) "APhA's William Apple Endorses Compulsory Continuing Education," Amer. Druggist, 31 (May 22, 1967)

9.) "Report of the Special Tripartite Committee on Continuing Education," Am. J. Pharm. Ed., 35, 467 (August, 1971)

10.) "The Continuing Education Pamphlet: Uniform Professional Continuing Education Act", National Association of Broads of Pharmacy, Chicago, Illinois (1972)

11.) "Professional Affairs Reference Committee Report," JAPhA, NS14 (9), 494 (September, 1974)

12.) Ibid., 493

13.) "Final Report of the AACP/APhA Task Force on Continuing Competence - The Continuing Competence of Pharmacists," JAPhA, NS15 (8), 432 (August, 1975)

14.) Griffenhagen, G. B., "Out of the pressure Cooker," JAPhA, Ns15 (8), 431 (August, 1975)

15.) "APhA - AACP Launch First Phase of Competency Project," APhA Weekly, 15 (6), 2 (February 7, 1976)

16.) Day, R. L., "Defining Practitioner Competency: The Development and Rational of a Currently Operating Model," Am. J. Pharm. Ed., 39 (5), 569 (December, 1975)

17.) "Commentary on the Question of Accreditation," Il. Pharm., 39 (5), 169 (May, 1975)

18.) "Accreditation of Continuing Education in Pharmacy - The Final Reprot of the APhA, AACP, NABP Joint Committee on Accreditation," 2 (June 3, 1975).

19.) "Accreditation of C.E. - Evaluation Process," American Council on Pharmaceutical Education, press release (September 25, 1975)

20.) Compentence as defined in "Evaluatinn in the Continuum of Medical Education - A Report of the Committee on Goals and Priorities of the National Board of Medical Examiners, Philadelphia, (June, 1973)

21.) "Guidelines for Continuing Pharmaceutical Education," Am. J. Pharm. Ed., 36, 634 (1972)

22.) Swafford, W. B., "Policies and Objectives of Continuing Education," Am. J. Pharm Ed., 29 (4), 571 (November, 1965)

23.) "Report of the Illinois Pharmaceutical Association Organizational Affairs Committee Sub-Committee on Continuing Education, "IL. Pharm., 36 (10), 303 (October, 1972)

24.) Houle, C. O., "The Nature of Continuing Professional Education," JAPhA, Ns15 (8), 438 (August, 1975)

25.) Pellegrino, E. D., "Continuing Education in the Health Professions," Amer. J. Pharm. Ed., 33 (5), 712 (December, 1969)

26.) Blockstein, W. L., "Developing a Program for Continuing Education for a College of Pharmacy," Am. J. Pharm. Ed., 33 (5), 767 (December, 1969)

27.) Sauter, R. C., "The Dynamic Role of Continuing Education in Pharmacy," Am. J. Pharm. Ed., 35 (4), 614 (November, 1971)

28.) Knox, A. B., "Continuing Education of Pharmacists," JAPhA, NS15 (8), 442 (August, 1975)

29.) Lawrence, G. D., "Voluntary or Compulsory ... Continuing Education." JAPhA, NS9 (10), 510 (October, 1969)

30.) "Statement on Continuing Education", Am. J. Hosp. Pharm., 29, 580 (July, 1972)

31.) Bloom, B. S. et al., Taxonomy of Educational Objectives, Handbook I: Congnitive Domain, David McKay Co., New York, (1956)

32.) Drumheller, S. J., Handbook of Curriculum Design for Individualized Instruction: A Systems Approach, 2th Ed., Educational Technology Publ., Englewood Cliffs, New Jersey, 34 (April, 1972)

33.) Rozinski, E. F., "Strengthening Professional Competence," JAPhA, NS13 (8), 403 (August, 1973)

34.) Tice, L. F., "Mandatory Continuing Education?," Am. J. Pharm. 146 (1), 3 (January-February, 1974)

35.) Swartz, M. A., "A Comprehensive Curriculum for Continuing Education in Pharmacy." Am. J. Pharm. Ed., 39 (3), 327 (August, 1975)

36.) "Guidelines for Continuing Pharmaceutical Education", Am. J. Pharm. Ed., 36, 640 (1972)

37.) Dowling, W. D., "How to Identify Needs of Groups for Continuing Education," Am. J. Pharm. Ed., 33 (5), 721 (December, 1969)

38.) White, A. I., "Continuing Education for Pharmacists," Tile and Till, 58 (2), 27 (June, 1972

39.) Mrtek, R. G., et al, "Current and Long Range Objectives for Continuing Education," IL. Phar., 39 (5), 163 (May, 1975)

40.) Daniels, W. A., "Variations in Needs of Pharmacists for Continuing Education," Am. J. Pharm. Ed., 33 (5), 733 (December, 1969)

41.) "Education for Pharmacists: Should It Be Learned or Else?," Drug Topics, 17 (April 24, 1972)

42.) "Schools Must Gear for Continuing Education," Amer. Druggist, 43 (May 4, 1970)

43.) Green, M. W., and Nona, D. A., "Annual Report to the Sponsors of the American Council on Pharmaceutical Education." Am. J. Pharm. Ed., 39 (4), 493 (November, 1975)

44.) "How Changes in Pharmacy Education Will Affect Pharmacy Practice," Amer. Druggist, 25 (November, 1975)

45.) "U.S. To Support Continuing Education," Amer. Druggist, 29 (March 28, 1966)

46.) Hodapp, W. J., "Continuing Education or Mental Titillation? Administrative Commitment Holds the Answer," Am. J. Pharm. Ed., 37 (1), 65 (February, 1973)

47.) Arndt, J. R., et al, "Participation of Wisconsin Pharmacists in Continuing Education, 1969-1973: A Preliminary Report," Am. J. Pharm. Ed., 39 (3), 264 (August, 1975)

48.) Bernardi, V. W., "An Analysis of Pharmacist Participation in and Attitudes Toward Continuing Education," Am. J. Pharm. Ed., 39 (3), 266 (August, 1975)

49.) Gross, S. M., et al, "Continuing Education in a Large Metropolitan Area - New York City," Am. J. Pharm. Ed., 39 (3), 271 (August, 1975)

50.) Kirk, K. W., et al, "Opinions of Women Pharmacists Toward Continuing Education," Am. J. Pharm. Ed., 37 (1), 72 (February, 1973)

51.) Barr, M., "Expereiences with a Continuing Education Series in Pharmacy of Medicinals," Am. J. Pharm. Ed., 29 (1), 78 (February, 1965)

52.) Dickson, W. M., and Rodowskas, C. A., "A Determination of the Feasibility of Establishing a Pharmacy Continuing Education Resource Directory," Am. J. Pharm. Ed., 39 (1), 43 (February, 1975)

53.) Gross, S. M., "A Study of the Relationship of Continuing Pharmaceutical Education to Selected Demographic Attitudinal and Competence Related Criteria," presented before the AACP Conference of Section of Teachers of Continuing Education, 13th Annual Meeting, Kiamesha Lake, N.Y. (July, 8-9, 1975)

54.) Braucher, C. L., "Trends in Pharmaceutical Continuing Education," Am. J. Pharm. Ed., 35 (2), 205 (May, 1971)

55.) Haakenson, P. N., and Hammel, R. W., "A Cost Benefit Analysis of Continuing Pharmaceutical Education," Am. J. Pharm. Ed., 38 (2), 215 (May, 1974)

56.) "We'll Pay Rx Men for Refresher Time," Amer. Druggist, 27 (March 13, 1967)

57.) Jobe, B. D., and Evanson, R. V., "The Pharmacy Practitioner's View of Continuing Education: Interpretations from a Research Study," presented before the AACP Conference of Teachers, Section of Teachers of Continuing Education, Annual Meeting, San Francisco, California (March 26, 1971)

58.) Carlin, H. S., "Continuing Education Requirements for Institutional Pharmacy Practice," Am. J. Hosp. Pharm., 24, 188 (April, 1967)

59.) "Gallina, J. N., and Jeffrey, P., "Pharmacist Standard for Maintaining Professional Competence," Am. J. Hosp. Pharm., 31, 943 (October, 1974)

60.) Hartshorn, E. A., "In Continuing Education the Pharmacist Must Be Both Teacher and Student," J. Am. Hosp. Assoc., 42, 105 (January 16, 1968)

61.) "Will U.S. Take Over Continuing Education of MDs. . . And Rx Men?," Amer. Druggist, 21 (January 16, 1967)

62.) Grupp, G., "Audio-Visual Media for Continuing Education," Amer. J. Pharm. Ed., 33 (5), 754 (December, 1969)

63.) Blockstein, W. L., and Durant, W. J., "Continuing Education and the Tele-Conference Technique," Am. J. Pharm. Ed., 32, 619 (1968)

64.) Hodapp, W. J., and Kanun, C., "Measurement of Relative Effectiveness of Programmed Instruction and Close Circuit Television as Adult Education Tools," Am. J. Pharm. Ed., 34 (2), 241 (May, 1970)

65.) Bradberry, C., and Courley, D. R., "An Innovative Coordinated Approach in Continuing Education," Am. J. Pharm.Ed., 38, 554 (November, 1976)

66.) Hodapp, W. J., and Walker, A. W., "An Experiment in Continuing Education Utilizing Closed Circuit Television," Am. J. Pharm. Ed., 32, 625 (1968)

67.) Arndt, J. R., and Weinswig, M. H., "Classroom Without Walls: Continuing Education Courses for Pharmacists via Cassette Tape Recordings," Am. J. Pharm. Ed., 37 (1), 61 (February, 1973)

68.) "U. of Wis. Develops Cassette Courses." IL. Pharm., 36 (1) 27 (January, 1972)

69.) Goldstein, F. J., "Continuing Education via Cassette Tape - Pharmatapes," Am. J. Pharm., 144 (4), 105 (July-August, 1972)

70.) Blank, J. W., "Evaluation of an AudioCassette Tape Lecture Course," Am. J. Pharm. Ed., 39 (5), 275 (August, 1975)

71.) Zillmer, W. A., "A New Approach to Continuing Education," Am. J. Hosp. Pharm., 28, 597 (August, 1971)

72.) Provost, G. P., "A New Dimension in Continuing Education," Am. J. Hosp. Pharm., 25, 211 (May, 1968)

73.) Schieve, J. F., "Techniques in Teaching the Adult," *Am. J. Pharm. Ed.*, 33 (5), 759 (December, 1969)

74.) "Individual Study For Adults at the University of Illinois." Report Submitted to Vice President Eldon Johnson, University of Illinois, Champaign, Illinois (July, 1974)

75.) Blockstein, W. L., "The Future of Continuing Education in Pharmacy," *JAPhA*, NS13 (8), 406 (August, 1973)

76.) Weinstein, M., and Fisher, D., "The Role of the University in Continuing Education," *IL. Pharm.*, 39 (5), 173 (May, 1975)

77.) "Phones Used For Continuing Education," *Amer. Druggist*, 27 (April 25, 1966)

78.) "Continuing Education by Computer," *Amer. Druggist*, 43 (June 29, 1970)

79.) Barnes, B. A., "Continuing Education by Correspondence, *Am. J. Pharm. Ed.*, 33 (5), 826 (December, 1969)

80.) "Tennessee School, Men J Join in Continuing Education Program," *Amer. Druggist*, 26 (November 13, 1972)

81.) "College Offers New Mail Course," *Amer. Druggist*, 51 (March 23, 1970)

82.) Mrtek, M. B., and Mrtek, R. G., "The Potential of Programmed Review Materials in Continuing Education," *Am. J. Pharm. Ed.*, 35 (2) (May, 1971)

83.) Campbell, R. K., "Programmed Learning Courses - A Source of Continuing Pharmaceutical Education," *JAPhA*, NS13 (8), 413 (August, 1973)

84.) The Chronicle, Albany College of Pharmacy, Albany, New York (December, 1975)

85.) "Guide to Continuing Education in Pharmacy," *Amer. Druggist Merchandising*, 37 (December 1, 1973)

86.) Kirk, K. W., and Weinswig, M. H., "Mandatory Continuing Education for the Relicensure of Pharmacists," *Am. J. Pharm. Ed.*, 36, 48 (February, 1972)

87.) Rodowskas, C. A., "Power of the Press," *Amer. Druggist*, 12 (February, 1976)

88.) Tice, op. cit., 4

89.) Rogers, C. R., Freedom to Learn, Merrill Pub. Co., Columbus, Ohio, 104 (1969)

90.) Knox, A. B., "The Case for Voluntary Continuing Education," IL. Pharm., 39 (5), 174 (May, 1975)

91.) Weinstein, M. M., "Mandatory Continuing Education and the Sub-committee on Continuing Education," IL. Pharm., 36 (10), 320 (October, 1972)

92.) Sloas, H. A., et al, "Patient Medication Profile Systems in the State of Florida," JAPhA, NS15 (9), 499 (September, 1975)

93.) "Professional Affairs Reference Committee Report," JAPhA, NS14 (9), 495 (September, 1974)

94.) Mrtek, op. cit., 164

95.) Parks, L. M., "Continuing Education - Putting the Cart Before the Horse," JAPhA, NS15 (8), 448 (August, 1975)

96.) "Professional Affairs Reference Committee Report," JAPhA, NS15 (6), 333 (June, 1975)

97.) Griffenhagen, G. B., "Measuring Up to the Challenge," JAPhA, NS15 (11), 613 (November, 1975)

98.) Knoben, J. E., "The PSRO Program - Its Impact on the Provision of Drug-Related Services," JAPhA, NS15 (11), 614 (November, 1975)

99.) DeMarco, C. T., "PSRO's and Pharmacy," Am. J. Hosp. Pharm., 30 (8), 723 (August, 1973)

100.) Hightower, A. B. and Griffin, J. W., "Peer Review: An Adventure in Real Life," Phys. Ther., 54 (9), 943 (September, 1974)

101.) Scott, J. C., "Utilization Review, Medical Audit, and Peer Review," J. Repro. Med., 12 (2), 57 (February, 1974)

102.) Barish, N. H., and Collins, W. K., "Peer Review for Quality Care in Private Solo Dental Practice," JADA, 89 (4), 866 (October, 1974)

103.) Chase, R. A., "Assuring Physician Competence: A Shared Professional Responsibility," The National Board Examiner, 22 (8) (May, 1975)

104.) Garb, S., "Letter", Fed. Proc., 33 (4), 1030 (April, 1974)

105.) Perlman, L. V., "Process and Outcomes in Medical Consultations: Evaluation on a Pulmonary Service," Postgrad. Med., 57 (4), (April, 1975)

106.) Trout, M. E., "Therapeutic Freedom," J. Legal Med., 2 (5), 36 (September-October, 1974)

107.) Schaffarziek, R. W., "Utilization and Peer Review: Medicine's Priviledge and Responsibility," Calif. Med., 113 (2), 80, (August, 1970)

108.) Goldstein, R. L., et al, "Data for Peer Review: Acquisition and Use," Ann. Int. Med., 82 (2), 262 (February, 1975)

109.) Payne, B. C., "EMCROs and the Evaluation of Medical Care." Ann. Int. Med., 82 (2), 276 (February, 1975)

110.) Winterfeldt, E., "Professional Standards Review Organizations (PSROs)," J. Am. Diet. Assn., 65 (6), 654 (December, 1974)

111.) Clark, R. R., "The Impact of a Computerized Peer Review System on Continuing Medical Education," Ohio State Med. J., 70 (12), 748 (December, 1974)

112.) ibid., 751

113.) Fraley, L. E. and Vargas, E. A., "Academic Tradition and Instructional Technology, J. Higher Ed., (January-February, 1975) in publication

114.) Fisher, D. J., and Weinstein, M. M., "Clinical Community Pharmicist: A New Dimension in Pharmacy's Future," IL. Pharm., in publication

V

MANDATORY CONTINUING EDUCATION AND INSTITUTIONS OF HIGHER EDUCATION

MANDATORY CONTINUING EDUCATION AND PROFESSIONALS: THE RESPONSIBILITIES OF POST-SECONDARY INSTITUTIONS

Morton W. Weir
Vice Chancellor For Academic Affairs
University of Illinois At Urbana-Champaign

INTRODUCTION

Although the title of my presentation mentions the "Responsibilities of Post-Secondary Institutions", and although I shall attempt to take into account the diversity of such institutions, it should be recognized from the outset that I shall concentrate upon the type of institutions which I know best: the comprehensive university with undergraduate, graduate, and professional programs; and of course I shall not be able to ignore the fact that the University of Illinois is a land-grant institution, and as a result, the level of our commitment to continuing education has been high for many years. I assume that this gives me as an administrator a somewhat different outlook than would be the case if Urbana-Champaign did not have such a strong land-grant tradition.

There is no doubt in the minds of most of us in post-secondary education that continuing professional education is important. It is important for the professional, for their employers, for professional societies, and for the public at large. And, in my view, continuing professional education will prove to be increasingly important for the health of the post-secondary institutions themselves.

There is also no doubt that post-secondary institutions are and should continue to be heavily involved in the offering of programs to professionals. The need and the demand for continuing professional education is increasing and the interest of institutions of higher education in expanding their services in these areas is also increasing (though perhaps not as rapidly as the demand). There are, I am sure, many reasons why the demands are growing so rapidly. The most obvious, and perhaps the most important, is the rapid growth of knowledge and technology. Our society is changing so rapidly that professionals may, if they are not diligent in keeping up with the pace of new developments, find themselves outdated in a decade or two. At least in some fields. It has been estimated that it took 150-200 years for the technology related to the invention of the steam engine to be diffused broadly throughout populations of users, while only 15 years was required for a similar diffusion of the transistor.[1] Such rapid diffusion of new technology obviously creates a new set of problems for the practicing professional. Whereas previously, keeping up with progress was an intergenerational phenomenon, it is now an intragenerational one, and therein lies the major force behind continuing professional education. The professionals more and more find themselves in the Alice-in-Wonderland condition expressed by the Queen when she said: "It takes all the running you can do, to keep in the same place."

When you consider that not only do professionals need to add new skills and knowledge to their repertoire, but they also forget some of what they have learned and therefore need refresher experiences, we again get back to the Queen in Alice who said "If you want to get somewhere else, you must run at least twice as fast as that."[2]

There is no doubt that the rate of technological advance and of change in general in our society is having a substantial impact upon those in professional practice. One study of librarians showed that their desire to learn about library automation was not related to whether or not their own libraries were automated. Instead, the high demand "seemed to be caused by the anxiety feelings the respondents had, fearful that they might need automation in their jobs in the future."[3] To cite another example: in a study of 125 engineers who had been laid off, only one variable revealed itself as consistently true in their backgrounds: none had engaged in any continuing education during the prior six-year period.[4]

So it seems increasingly clear that continuing professional education is important, it is here to stay, and it is growing rapidly. But most such education is and has been voluntary. The advent of mandatory participation in continuing education raises new questions and challenges for higher education, especially when such requirements are intended at least in part to protect the public against substandard performance. And those of us in higher education should be aware of the many problems and pitfalls which lie ahead as continuing professional education increases in its mandatory aspects. Many questions are being raised about the desirability of mandatory continuing professional education. For example, should great time, effort, and money be spent in requiring that all members of a profession take part in certain specified types of continuing education, when it may be only a small fraction of the profession whose performance is a threat to the public welfare? And if a principal motivator for the mandatory requirements is protection of the public, what are the special responsibilities and liabilities of those institutions which offer experiences designed to fulfill such requirements?

These and many other questions will pose unusual problems for post-secondary institutions--problems of cost and accountability which probably will be much more extensive than those we face today (and which are themselves onerous enough). But surely these problems have solutions, and I believe that faculty members in post-secondary institutions can and should play important roles in helping find their solutions. If we shy away from this task because of the difficulties inherent in it, I believe that the effort itself will suffer, and so will the institutions. On balance, it is my view that post-secondary institutions can benefit greatly from taking an active role, and the remainder of my remarks will emphasize the nature of that role, at least as I see it. But we must keep three things firmly in mind:

First, many of us have grave doubts about the mandating of continuing education. You have heard two deans from the Urbana-Champaign campus--Dean Cribbet of the College of Law in his introduction of President Corbally and Dean Drucker of the College of Engineering last night--make negative or cautionary statements regarding the mandatory aspect. Although I am not as negative as Dean Cribbet on this matter, I nevertheless believe we should progress with great care. Second, although I shall stress the role of post-secondary institutions, I by no means believe they should play the primary role. An important role, yes, but its extent should be determined only after comprehensive planning and considerable experience. Third, and most important, the main role of educational institutions is to increase competence and knowledge through teaching and scholarship, not to police professional practice.

To Critique The Concept of Mandatory Continuing Professional Education

Let me move now to the several roles which I see for higher education. The first role in which institutions of higher education can be of help is to provide a critical appraisal of the concept of mandatory continuing professional education itself. As President Corbally stated in his opening address, today the "feet of clay" of professional "seem almost more visible than their loftier features." Public pressure is mounting on such groups as professional associations and state licensing boards. Faculty members in higher education can help to analyze the nature of the problems creating these pressures, and critique plans which are proposed for their solution. It will be regrettable if, in order to counter bad publicity, bad legislation is written. We must understand, in detail, the nature and the extent of the deficiencies among practicing professionals; and we must understand, in detail, the nature of the programs to remedy those deficiencies, their costs, and their benefits.

I am reminded of one of the cornerstone programs of the war against poverty: Project Head Start. A need had been identified, but not with great understanding. Legislation was written, funds provided, and during the process many in the child development field in educational institutions and elsewhere were raising fundamental questions about the advisability of moving so rapidly with so little attention being given to the details. They were correct in their concerns. Head Start, in my opinion, did (and does) much which is good, but it would have been infinitely more effective if a significant amount of time had been spent in careful research, analysis and planning.

If we are not careful, the same thing could happen in mandatory continuing professional education. And faculty members in post-secondary institutions can, I believe, aid greatly in the task of deciding if certain kinds of mandatory programs are indeed the most fruitful means of approaching this situation. If, after all, the need for mandatory programs is the result of perceived deficiencies or substandard performance, how much will be accomplished if the mandated program is merely to have the professional attend a certain number of hours in a classroom? Those of us in higher education need to critique such proposals; we must be sure that they can accomplish what they are designed to accomplish.

Assessing Needs and Setting Priorities

The second role in which institutions of higher education can provide help is in assessing needs and in setting priorities. There are two aspects of assessing needs which require attention: determining what a professional needs to know, and establishing methods for determining which professionals do in fact know what they need to know. (Some may object to my stressing "What a professional needs to know", but I believe that is the essential aspect of mandatory continuing professional education.)

Faculty members by and large will not be greatly helpful in the decision as to what a professional needs to know. True, many have had experience in a profession other than teaching. And it is also true that many engage in professional practice to keep fresh their contacts with the profession. But they do not spend their time, day in and day out, serving as practicing physicians, or lawyers, or engineers. Thus, it seems to me that the role of post-secondary institutions in the assessment of needs will fall more heavily in the second aspect: establishing methods for determining which professionals know what someone decides they need to know. Here, we can be helpful. We have specialists who can and should be actively involved in such tasks. Such effort is also a part of the evaluative aspect which I shall mention later.

The same general notions apply to the setting of priorities. I believe that faculty members can help with the methodology of determining what is most important or more important; but they will be much less helpful in actually identifying the specific knowledge or skills which are of the highest priority.

The Planning of Programs and the Establishment of Responsibility for them

Once needs are identified and priorities established, programs must be developed and agencies must be assigned the responsibility for conducting them. Again, given the likely nature of mandatory continuing professional education, the planning and conducting of programs must recognize the diversity of publics to be served and the diversity of institutions that are available to serve them. The professionals themselves, their societies, their employers, and faculty in the educational institutions must work together in planning the programs and experiences which are to be required. And these same groups must also come to agreement on the division of responsibility for the conduct of the programs. Some segments will best be done by the profession itself--a Bar Association, for example; other segments might well come through on-the-job experience, largely provided by employers; still others will be appropriate for the interest and training of faculty at the community colleges; and so on.

I believe that upon careful examination of the programs which need to be presented, those of us in higher education will find that our skills will complement each other and those of the individuals in other groups, such as the professional societies. For example, an instituion such as the University of Illinois at Urbana-Champaing should not attempt to offer programs of continuing professional education to persons such as dental hygienists, practical nurses, or respiratory therapists. These are, by and large, community college programs and the programs are generally of high quality. Even if we at Urbana-Champaign decided that we should begin to offer such instruction, we would probably do a poorer job of it than would our neighboring community college.

We may be able to provide some help, however. The Community College may wish to have research done on certain aspects of their curriculum; they may request help in evaluating their program; certain of our faculty may help in presenting particular aspects of a topic; we may aid in staff development; and so forth. It is in this way that I see the potential for complementarity in the offering of such programs. We should avoid, if we can, empire-building and turf-protection; the task before us is a large one indeed, and if it is to be tackled effectively such territorial urges will have to be suppressed.

Conducting Mandatory Continuing Professional Education Programs

I now move to the role of post-secondary institutions in the actual offering of programs related to mandatory continuing professional education. There are several compelling reasons why institutions of higher education, and especially universites, should be actively involved: First, higher education has been the principal site for the original preparation of professionals. It is therefore logical to assume that we should also be heavily involved in continuing professional education; Second, most institutions of higher education have defined their instructional function to include adults who study part time in credit and non-credit programs; this is particularly true of community colleges and land-grant schools; third, the teaching of professionals is well-suited to the training of skills of the faculty, perhaps more so than teaching freshmen or sophomores; and fourth, interacting with professionals on a regular basis will allow the faculty member to bring back to his or her on-campus teaching and research a wealth of practical information. This latter aspect is important for it is essential that this type of teaching be mutually beneficial--that is, beneficial both to the professional and to the faculty member.

Even though it seems obvious that higher education must be involved in these mandatory programs, there are nevertheless some major obstacles and problems to be overcome. For example, the mandatory nature of the programs will likely result in the identification of a highly specific set of skills or body of knowledge that must be mastered. Faculty prerogatives and initiative may be stifled if the material is too rigidly prescribed, pointing again to the need for both professionals and faculty members to be involved in the planning of such programs. Also in many fields, professionals will wish to work toward an advanced degree or certificate. But many universities have so-called "residency requirements" which stipulate that a certain fraction of the work must be done on campus, making it difficult if not impossible for the professional to complete the requirements without a substantial disruption in his or her professional work schedule. Institutions must examine carefully such requirements and retain them only if residency is necessary to assure that the quality of instruction is equivalent to that offered on campus.

Evaluation of Programs

Another area in which institutions of higher education can play a key role is in evaluation. All programs offered in the public service sector should be evaluated from time to time. Higher education, though possessing many persons whose specific field is measurement and evaluation, has been nevertheless slow to apply these techniques to its own programs. Some campuses--the University of Illinois at Urbana-Champaign is a good example--have had comprehensive programs of evaluation in progress for a number of years; but many other institutions have just begun or have not begun at all. Programs of mandatory continuing professional education will require detailed evaluation on a routine basis. They cannot--and should not--continue without such evaluation. Why do I stress this aspect when colleges and universities have not routinely evaluated their other programs? My reason goes back to the concept of protection of the public. Many mandatory programs will come about through peer pressure and through pressure from the public. This implies that specific deficiencies are to be corrected and specific results should occur; and there is no way that programs with such aims and such costs can void close scrutiny--"accountability", as it is now called.

College and university faculties can be of enormous benefit in this evaluative aspect. We have groups of experts in educational measurement, in evaluation, and in survey research. The evaluation of mandatory programs would not only be professionally satisfying to many of them, it would also tie in well with their on-campus teaching and research. In some ways, such evaluations would be similar to those now in progress with civil service and other entry-level examinations as their subject. Questions have been raised as to whether or not such examinations are job-related, and invididuals in the field of tests and measurement are being called upon to provide answers--and to develop new examinations where necessary. Mandatory continuing education programs will undoubtedly be job-related; and it will be necessary, just as in the case of civil service examinations, to determine the validity of the experiences being required.

But we should anticipate that the evaluative task will be very complex, and will lead the evaluators into areas which they seldom venture. The task will be complex because such programs will vary greatly in sponsorship, purpose, and method. Evaluators will be walking unfamiliar paths because such mandatory programs will vary also in their desirability and in their importance and public visibility. It is one thing to evaluate a pre-school curriculum for the handicapped, and quite another to evaluate the effectiveness of continuing education programs for physicians or lawyers, especially when the public may be insisting upon improved practice as an outcome of the mandatory programs. I make these comments to emphasize that although institutions of higher education are the home of many of those who are expert inthe evaluation of educational programs, the difficulties which are likely to inhere in the measurement of the effectiveness of programs of mandatory continuing professional education will pose formidable problems to anyone involved in their evaluation.

Pioneering New Developments

I move not to the last category of responsibility which I see for postsecondary institutions in the field of mandatory continuing professional education: that of pioneering new developments. Clearly, new developments should be cooperatively produced, for they will in many cases be tied both to new discoveries in a field and to new aspects of professional practice. And occasionally, new developments will originate from advances in the technology of communication, such as the PLATO computer-aided instruction system at Urbana-Champaign.

As faculty members aid inthe assessment of needs and evaluate the programs which are offered, many opportunities will arise to develop new strategies and techniques. Such opportunities will include both research and development activities and the field trial of new delivery systems. This is a very important aspect for the faculty member, for many individuals, particularly in universities, will continue a lively interest in such mandatory programs in direct proportion to the degree the programs provide a stimulus for research and development.

Summary

To summarize: Higher education is now heavily involved in continuing education, both to professionals and to others. Higher education should also be heavily involved in mandatory continuing professional education. Although we have no easy solutions to offer and the problems are many, the programs will suffer greatly if post-secondary education does not play an active role. I see the responsibilities of higher education falling in six broad areas: the critical analysis of the concept of mandatory continuing professional education; the assessment of needs and the setting of priorities; the planning of programs and the establishment of responsibilities for carrying them out; the offering of the programs themselves; the evaluation of the programs and the pioneering of new developments. It is in the latter three areas; conducting programs, evaluating them, and developing innovative approaches, that I see the most extensive role for higher education.

References

1. Mesthene, Emmanuel G. *Technological Change: Its Impact on Man and Society*, Cambridge: Harvard University Press, 1970, p. 24.

2. I am indebted to Dorothy J. Hutchinson, "The Process of Planning Programs of Continuing Education for Health Manpower" in A.N. Charters and R. J. Blakely *Fostering The Growing Need to Learn* (Wash., D.C., PHS/DHEW, 1974) for pointing to the wisdom of Lewis Carroll in this matter.

3. Stone, Elizabeth W. *Continuing Library Education as Viewed in Relation to Other Continuing Professional Education Movements*, Wash., D.C.: American Society for Information Sciences, 1974, pp. 9-13.

4. Ibid

EVIDENCE FOR THE EFFECTIVENESS OF CONTINUING PROFESSIONAL EDUCATION AND THE IMPACT OF MANDATORY CONTINUING EDUCATION

Cyril O. Houle
Professor of Education
The University of Chicago

The planning committee, in assigning the topic for this paper, clearly showed that it wants facts, not opinions. Perhaps the members had in mind the great Swedish-born physiologist, A. J. Garlson, who terrorized several academic generations of American colleagues. They knew that any unguarded word on their part was sure to lead him to ask "Vot iss your effidence?" I have been directed by the committee to provide evidence to answer two questions. How effective is continuing professional education? How is that effectiveness changed if the education is made mandatory? I shall do the best I can to respond but I am glad Professor Garlson is not here.

II

Two key ideals of professionalism are individual integrity and social responsibility. Their proper harmony in the routines of daily practice undergirds the theme not only of this paper but also of this whole conference. Wherever else it may lead, education must begin with the single practitioner. Ideally each professional solves problems and learns from their solutions, locates and ponders the distinctive element in every situation however commonplace it may seem, talks with colleagues or with salesmen, collaborates with associates, reads books and journals, attends the meetings of learned societies, goes to conferences visits other work settings, uses the new media of communication and facilitation, and takes study leaves. Sometimes the people who engage in such activities seek additional rewards, such as recreation or escape from responsibility but their dominant motives, it is generally agreed, should be the exercise of a recognized responsibility or the belief that such activities will help their personal growth and their professional expertness. How is the accomplishment of these goals measured?

The great expansion of continuing education itself indicates in a powerful, though admittedly rough-hewn way, that the learners must feel some benefits from what they do. In addition, many of the hundreds of thousands of organized group ventures in continuing professional education which occur each year either include or are centered upon instruments and techniques of evaluation. Countless forms of measurement have been developed to assess how people feel about an educational experience, how much subject-matter they have mastered, and how expertly they have learned to perform skills. These instruments differ greatly in quality, but even the poorest of them show in a dim sort of way that a few of the participants have learned something. In self-appraisal examinations, which have had a recent vogue in the health professions, evaluation is related not to attendance at educational events but to how much a person actually understands. It is assumed that the professional is eager to discover how his or her areas of personal strength or deficiency balance out and what should be done about them.

None of these forms of assessment measure what everybody really wants to know. The task of a professional is not to feel good about the tasks to be performed, to know new subject-matter, nor to be able to perform skills. It is to apply sensitiveness, knowledge, and ability to the handling of a succession of particular cases. often under stressful conditions. As yet the science of assessment has not produced easily administrable, valid, and reliable instruments to determine the quality of actual personal performance. To get these data, it is necessary to rely on such anecdotal methods as peer, client, and supervisory reviews or upon personal self-reporting, all of which are highly subjective.

Suppose, however, we reverse directions. What if we did not investigate the process of education (which is merely a means to an end)? What if we looked instead at the end itself, the practice of the profession? The first thing we would be likely to notice is a great variability among practitioners in the quality of service they provide. Some of them are vastly more able than others in bringing about the results desired, such as healing patients, providing legal counsel for clients, teaching students, ministering to a congregation, preparing accurate financial statements, or waging war. This variable competence is associated with many personal and social factors but it is widely assumed that important among them is the relative rapidity with which professionals adopt new ideas and practices. To make this assumption permits me to bring within the scope of this paper the research on the adoption of innovations and how it is influenced by continuing education.

This literature has grown rapidly in many theoretical and practical fields. In 1971, Rogers and Shoemaker synthesized the results of about 1,500 investigations which had been conducted with many different groups throughout the world.[1] These studies usually have certain common elements. The innovation is defined in exact terms such as the use of a new drug or some other form of therapy, of new materials of principles of building construction, or of computerized or other time-saving techniques. The need for precision may lead researchers to be more concerned with concrete practices than with abstract conceptions, but that result is not inevitable. In any investigation, the population to be studied is then identified; for example, it might be all foresters in the western states, all hospital administators in major cities, or all optometrists practicing in Ohio. The innovation is set within the context of that population; a well-established practice among one group may be novel to another. The investigator then devises a method to measure the rapidity with which the innovation is adopted by the members of the sample used. If any factors, such as age, sex, socio-economic status, or extent of continuing education, are to be correlated with the process of adoption, they are defined and ways are found to measure them.

Rogers and Shoemaker, summarizing their 1500 studies,concluded that, in terms of the rapidity of adoption of an innovation, people are distributed along a normal bell-shaped curve. By laying off standard deviations from the mean, five categories of adopters can be identified. At the upper limit are the innovators who make up about 2.5% of the distribution and whose chief characteristic is venturesomeness. Below them on the curve are: the early adopters, 13.5%, respectable; the early majority, 34%, deliberate; the late majority, 34% skeptical; and the laggards, 16%, traditional.[2] The percentage estimates are for all samples studies. In the professions, the relative number of people in the various categories might well be substantially different than those just cited.

While it may seem obvious that there should be a linkage between rate of adoption and participation in continuing education, that relationship is also supported by research. I shall mention only two of many studies. Peterson and others found a positive correlation between a physician's skill in using new techniques and his interest in seeking new knowledge as evidenced by his subscription to professional journals.[3] Averill studied 397 farm operators in three Kansas counties. On the basis of the pooled judgment of a panel of qualified observers each farmer was identified as being, generally speaking, an innovator, a leading adopter, a majority adopter, or a laggard. Data on educational participation was secured by interviews and was measured in nine activities: reading specialized farm magazines; reading general farm magazines; reading general magazines; amount of book reading; recency of book reading; currency of book reading; class and correspondence study experience; conference and institute attendance; and discussion group participation. Differences among the four adopter groups were positively and highly significantly related to participation in the nine methods of learning. This fact was true even when the influence of age, formal schooling, and socio-economic status was statistically controlled.[4]

Further confirmation of these results is provided from other investigations. A close relationship exists between rate of adoption and each of the following factors: favorable attitude toward education; favorable attitude toward science; extent of contact with people whose function it is to bring about change; amount of exposure to mass media; openness to interpersonal channels of communication; extent of general social participation; cosmopolitanism as contrasted to localism; number of years of formal education; intelligence; and degree of specialization of practice.

Apparently, then, objective global evidence exists that continuing education is effective in changing practices. Some people might argue that this conclusion is meaningless, since innovations are sometimes transitory fads whose adoption should not be the measure of continued learning. Anybody who takes this position, however, must also assert that continuing education is concerned only with eternal verities, a fact which might be hard to prove.

III

No matter how wide the range of competence of the members of a profession, all of them presumably need continuing education. However, it is the laggards and the members of the lower middle majority whose incompetence drags down the reputation of professions, and therefore such people come most readily to mind when continuing education is considered. It is they who are felt to need mandatory learning, this view being urged either by the leaders of a profession or by an aroused public, both of whom properly stress the responsibility which should accompany the privileges granted to certified or licensed practitioners. (Professions are also harmed by the existence within their ranks of scoundrels, who may be at any level of competence, but few people argue that their moral deficiencies will be corrected by continuing education, except possibly that which a prison might provide.)

One difficulty in considering mandatory requirements for continuing professional education is that the punishments for not complying with them differ greatly. These penalties include: loss of the right to practice anywhere in the country or in a specific state, county, or city; loss of the right to practice some functions but not others; loss of the right to provide service in certain places, such as hospitals, or to certain persons, such as patients on a third-party-payment health plan; loss of membership in an association; forfeiture of the right to increased compensation; or inability to display a new certificate rather than an old one.

The idea of mandatory continuing education is relatively new in most professions. One of them, however, has had a fullscale, long-tern, and complete involvement with the issue, including, in one way or another, all of the rewards of participation and all of the penalties for abstention. This profession is school-teaching compulsion for teachers to continue their education has been applied at many points: the revalidation of general and special licenses; the establishment of salary schedules; the supervision of practice; the requirement that paid time be used for profession-oriented or school-oriented study; and eligibility of membership in associations.

In carrying out mandatory continuing education, the leaders of school-teaching have been extraordinarily resourceful. The chief method used has been registration in college or university courses, which are sometimes counted separately, sometimes accepted in sequences. Other techniques have also been used: examinations; conferences, conventions, and workshops of every conceivable variety; skill training checked by tests of competence; and the use of telephone linkages, field staffs, radio, television, and other devices of communication. The school has become a center for the in-service education of teachers, using supervision, curriculum planning, imported courses and lectures, retreats, professional staff meetings, and many other techniques. The accepted doctrine of the profession is that mandatory continuing education is essential, and that doctrine has been widely practiced since this century began.

What has been the impact of this policy on the profession? No absolute answer can be given to the question since no parallel exists with which to compare the American experience. It seems to me, however, that the net results have been better than if mandatory continuing education had not existed. In the 1840s, this country decided to provide egalitarian education on a social and geographic scope unparalleled in history. This nation had to train a vast corps of teachers who could reach out everywhere and to everyone. As early as 1900, it was realized that continuing education was necessary to strengthen the competence of the teachers who staffed the schools, many of whom would not have continued to learn without strong positive inducements.

These same conditions applied to all other professionalizing occupations, including medicine and law. For some reason, beginning about 1910, they chose to concentrate all their attention upon the pre-service years of preparation and are only now having to adopt mass continuing education as an addition to an already well-established system. Should school-teaching have followed the sa policy or should other professions have followed the model used by school-teaching? Who can say? In the end they are all likely to come out at same place.

It is clearly true that teaching is not now esteemed as foremost among the professions. Moreover, the past ten years the practices of almost all professions have been subjected to blistering attacks; perhaps only medicine has suffered more of them than teaching. It seems safe to conclude, therefore, that anybody who believes that vocations can build public favor or withstand general criticism by adopting mandatory continuing education should ponder the example which school-teaching provides.

Another difficulty arises from the fact that even though continuing education may be mandatory, the profit derived from it differs greatly from one learner to another. Some students in a course or conference may respond enthusiastically to the material presented and give evidence later on having fully incorporated its lessons into daily practice. Other people sharing in the very same activity may do the minimum work possible, get the least allowable grade, and subsequently show no sign of ever having taken the course. Yet both groups have met the mandatory requirement and both will receive the same rewards. It is my firm conviction that the range from innovators to laggards will be observed as much in mandatory as in non-mandatory education.

Here we must return to the crucial theme of this paper, the need for adequate assessment. No objective and easily administered way to measure the influence of specific continuing education programs upon the improvement of performance has yet been found. We can therefore only assume that any activity now mandated by a profession by a profession or by a legislative body is positively related to the measure it would use if it could. I shall therefore list the activities which are most frequently mandated, but I shall put them in the order from low to high in which I believe that they correlate with the actual improvement of performance. They are: attendance at courses or conferences which do not evaluate learner accomplishment (this requirement might be negatively correlated with subsequent performance in the profession); attendance at courses which try to measure the learner's gain in satisfaction, content acquisition, or sensitiveness; attendance at courses which try to measure two of these attributes; attendance at courses which try to measure all three; performance on complex and professionally designed examinations; demonstration by the learner that he or she is able to perform well-established and broadly-based competencies; and successful completion of a previously approved plan of experience and study originally developed by the learner. There can be no immediate evidence that this order is the correct one. But please consider if it seems right to you and, if not, what other mandates you would include and in what order you would put them.

IV

At this time, we seem to have nothing better than these activities to satisfy our own concerns or those of consumers and social policy groups, such as legislatures. All availalbe evidence seems to show that lifelong professional education improves practice. As yet, it is only an article of faith that the addition of compulsion does much to change the situation. The center of our concerns, therefore, must be the creation of forms of assessment which measure or are provably correlated with what both professionals and the general society demand to know: how well does every licensed or certified practitioner maintain an alert continuing performance of his or her duties in as effective a fashion as the current knowledge base permits? The the extent that there is any deficiency in that performance, how can it be remedied?

References

1. E. M. Rogers and F. E. Schoemaker, Communication of Innovations. New York: The Free Press, 1971, p. 19.

2. Ibid., pp. 180-185.

3. O. L. Peterson, L. P. Andrews, R. S. Spain, and B. G. Greenberg, "An Analytical Study of North Carolina General Practice," Journal of Medical Education, 31, 1956.

4. T. B. Averill, "Educational Participation and Openness to New Ideas," Unpublished doctoral dissertation, The University of Chicago, 1964.

IMPACT OF MANDATORY CONTINUING EDUCATION ON THE PROGRAM DEVELOPMENT PROCESS

Floyd C. Pennington
University of Michigan Medical School

Planners of continuing education activities can find numerous articles about mandatory continuing education in the literature and the messages are mixed. One article urges that mandatory continuing education be stamped out:[1] the authors argue that these programs are predictable failures and that attendance does not influence the professional's practice. Other writers indicate that continuing education can help improve programs by: 1) introducing a variety of learning strategies; 2) emphasizing learner involvement activities; 3) providing continuing education at the local level where practice occurs; and 4) linking continuing education to needs clearly identified as important to professional practice.[2]

The planning process is not a static or linear set of actions that all planners follow. Some research[3] shows that planners of continuing education activities in several professions will attend to similar clusters of planning activities but no common sequence of specific actions within those clusters is apparent. There are activities that occur early in a planning process and others that occur later. Many factors determine what a planner will do and when that will be done. Mandatory continuing education requirements are just one set of factors planners will consider as they plan a single activity or develop a year's set of activities. The planning process can accomodate the intrusion of a few requirements.

For many planners, the imposition of mandatory continuing education requirements will have no impact on the way learning activities are planned. Other planners will make small alterations in their planning processes to accomodate external requirements. Still others may despair at the rigorous requirements they must adhere to in assuring their constituents that credit will be available for attending a particular activity.

There are two ways to consider the impact of mandatory continuing education on program development: 1) the impact on planning single learning activities such as a two-day short course; and 2) the impact on planning an organization's efforts for an extended period of time -- a year's offerings, for instance. The reader should consider the following comments from both perspectives.

There are at least four major impacts that mandatory continuing education requirements have on the program development process: 1) approval requirements; 2) instructional design; 3) public relations and marketing; and 4) administration.

Groups with mandatory continuing education requirements must create an approval process. Two parts of an approval process will impact the program development process; 1) the categories of activities that will qualify as approved continuing education activities; and 2) the criteria that will be used to judge what activities will qualify and the amount of time within each category that will be awarded and counted toward the annual minimum. Planners must know these requirements and develop activities most likely to meet the approval criteria.

The most general approval criteria stipulate that: 1) the planned activities must be developed around objectives that specify what participants should be able to do at the end of the learning activity; and 2) the learning activity must be evaluated so that the approval body will be satisfied that the stated objectives have been met. These criteria make educational sense and impact the process of instructional design. The astute observer, however, recognizes that many forms of continuing education will be hard pressed to assure the approval bodies that behavior has changed as a result of participation in their activities.

Consider activities planned by university extension groups which bring people together from all parts of a state for a two-day conference. Behavioral objectives are in place. The design of the course should facilitate the accomplishment of these objectives. Base-line data is gathered to describe where the learners are before the learning activity. An end of the course "test" shows changes in knowledge or even practice. Then the learners disperse. Do practices "back home" change? The application of new knowledge "back home" is often hindered by people and other organizational constraints. It would be economically and practically unfeasible to assure approval bodies that people have changed their practice behaviors as a result of participation in an approved course. Pushed to the literal interpretation of many mandatory continuing education approval regulations, this is expected. Clearly, other sponsors can document this kind of change. Programs done as in-service activities in the practice location can come much closer to fulfilling these requirements. The regulations, however, do not make allowances for these differences.

The impact being discussed is a positive one. Planners must specify learning objectives in terms of desired changes in participant behavior. Hoepfully, this includes changes in knowledge, skills and attitudes. Planners, to obtain approval, must take seriously instructional design decisions based on what learners will be able to know, do, or feel after the learning experience.

Many educators will laud this development. Others would challenge the notion of specified behavioral objectives as a legitimate and even possible basis of program development.

Another potential impact on instructional design could be the development of standardized learning packages from which all members of the constituent group must select to fulfill the minimum hourly requirement. It is much easier to plan one activity to be repeated many times throughout the year than it is to develop and obtain approval for many activities. Groups that approve single programs rather than institutions foster this type of conformity and standardization. The emphasis shifts from the changing learning needs of individuals in their work settings to a process of designing packages that will be easily approved. The focus becomes one of instruction and reporting rather than education and learning. The learners stand to lose if this movement becomes one of approving attractive educational packages that make instructional design look good but relate to learner needs only tangentially.

One outcome we can expect from mandatory continuing education is a movement toward large group sessions with lectures as the major delivery format. An influx of many more attendees will force this format on planners. The facilities available for large groups to be broken down into smaller workshops or conferences are limited.

Planners need not worry about motivating learners to attend. Now planners must motivate participants to actively engage in a learning activity which they may not want to attend. Learners who must attend are likely to bring a different set of interactions to a learning experience.

This leads to the matter of accountability of the sponsor. Having an approved program which must be evaluated in terms of changed behavior may bring with it a bizarre set of circumstances. Fantasize a bit. A nurse is being sued for malpractice. She failed to exercise appropriate actions in a coronary care unit. The prosecuting attorney finds that she recently attended an approved continuing education course that reviewed appropriate cardio-pulmonary resuscitation actions a nurse should take. How can you imagine that you as a program planner might become involved in a suit of this sort? It is not as far-fetched as it may seem. Recall the suit brought by a California high school graduate who could not read.

Agencies whose business is planning continuing education activities might see mandatory continuing education as a market boom. Planners dream of filled halls and balanced budgets. They dream also of a competitive market, but other groups will discover this market and begin to carve off a piece of the sandstone. The hoped-for boom in business may be short-lived. The groups that present the most palatable applications to approval bodies will be approved. Others will be forced to spice up their applications or risk denial. Planners then become marketeers who are expert in "advertising" their wares to the agency who will approve their product. The danger is that approval will be based on appearance rather than substance.

Another potential impact of mandatory continuing education on the program development process is "market" related, but has direct implications for administrative details. With mandatory continuing education, all members of the profession must accumulate a specified number of approved hours. In Michigan, for instance, physicians must now report fifty hours of continuing education each year or their licenses will be lifted. Twenty-five of these hours must come from formal educational experiences, usually translated courses. At the time the law was passed, only one sponsoring agency in the state was approved to offer accredited courses. If there were 10,000 physicians in the state (there are more) who must attend twenty-five hours of courses each year, that would mean this one approved agency must generate 250,000 course contact hours in one year. Fortunately, other sponsors are seeking accreditation and physicians can accumulate hours outside of the state. Physicians also have flexibility in the kinds of activities that can be counted toward that part of the fifty hour requirement. It would be nearly impossible for one group to generate that many contact hours in one year.

A matter of logistics that planners must consider is record keeping. With attendance required, the participants will demand proof of attendance, someone must provide that record and indicate the number of hours the participant has earned. I spoke recently at a meeting co-sponsored by three different groups. Each group granted a different number of C.E.U.'s for the course. Evidently, each group had a different formula for the total credit applications for each group. My guess is that each application required different information.

The final impact of mandatory continuing education requirements to be discusses is cost. There are visible and hidden costs. For organizations requiring approval for each activity, there are two evident costs: (1) man-hours to prepare the required application material; and (2) a processing fee required by the approval group. There will be costs of duplicating applications for your record and for presentation to the approval group. This takes material and man hours.

Most continuing education programs require the planning and preparation efforts of more than one person. The time these people spend in preparing and providing the required application information represents a substantial cost. Much of this, of course, occurs regardless of external requirement.

There are costs incurred by the approval body to cover the expenses of their operation. In some way, these costs are passed on to the sponsor, the consumer, or both.

If mandatory continuing education requirements create an increased number of learners seeking admission to available activities, the sponsoring group must accomodate the requests. This may mean obtaining a different kind of educational facility. It may mean more promotion costs, more costs for educational materials, and more indirect costs related to staffing and providing services to the course participants.

A variety of costs are imposed on the learner as a result of mandatory requirements. Persons living in more remote areas of a state must travel significant distances to gain access to approved programs. Beyond the travel, lodging, and tuition are costs to the employer of "lost" time from the job, costs that allow for the learner's services to be continued while attending the conference, and inconveniences imposed on the public as consumers.

Some sponsoring agencies attempting to be responsive to learners required to attend educational activities are examining alternative delivery formats. Gaining approval for mediated learning modules that can be presented at the practice location are beginning to be viewed favorably by approval bodies. This has not always been the case. This brings to the sponsor substantial development, production, marketing and dissemination costs. Many of the educational impacts discussed earlier apply to these attempts.

The list of costs impacts that might occur as a result of mandatory continuing education requirements could be extended even further. To provide learner groups with responsive and quality continuing education programs costs money. In many occupational groups, the consumer ultimately pays.

The impacts discussed in this brief statement have been negative. In my view, mandatory continuing education is not and cannot fulfill all of the lofty goals put forth by proponents. Many positive outcomes will occur as a result of these requirements. However, occupational groups should not be lulled into complacency and satisfaction, believing that now, with these interventions, service will improve for the consumer.

Mandatory continuing education requirements may do more to improve planning and implementing educational activities than changing practice behaviors. Occupational groups, including the most sophisticated professions, must approach the problem of quality practice through continued demonstration of competence. Continuing education may help maintain a person's competence. Requirements to continue practice, therefore, should not be based on a support system, but should be based on demonstrated competence.

References

1. Libby, Major Glidden Neil, et al. "Help Stamp Out Mandatory Continuing Education." JAMA, August 18, 1975, Volume 233, Number 7.

2. Richards, Robert K. and Stein, David. "Mandatory Continuing Education in Medicine: A Challenge to Adult Educators." NUEA Spectator, September, 1975.

3. Pennington, Floyd. Program Development in Continuing Professional Education: A Comparative Analysis of Process in Medicine, Social Work and Teaching. Unpublished Ph.D. dissertation, University of Illinois, 1975.

Notes on the workshop session "Impact of Mandatory Continuing Education on the Program Development Process"

I. The limits imposed on program development by the professional associations were of major concern to the participants of the workshop. These limits vary in their usefulness to learners and facilitators alike. Five limits which frequently occur are:

(1) programs must respond to an identified need;
(2) programs must include an evaluation design;
(3) programs must include stated objectives;
(4) a principal planner must be identified; and
(5) credit may be given for a limited range of informational categories.

In addition, each professional association or academy has its own criteria for programs. In other words, the limits described above vary for program development for each professional group and specialty group.

Another limit, often set by law, is that CPE must relate directly to the practice of that profession. In order that the need for different professional groups (e.g., medicine and insurance) understand one another, such laws would have to be interpreted loosely. Inter-professional exchanges could be developed at universities, where there are resource persons knowledgeable in many field. It was specifically suggested that university CPE units look for such matches.

II. A possible result of the various limits is standardization of programs. The standardization which exists at this time is much more responsive to the criteria of the academics than to the needs of individual learners. A planner may tend to repeat programs once they have been approved, without giving ongoing attention to the specific and/or emerging needs of learners. Whom to respond to - academy or individual - was a major concern.

Program planners must differentiate between repeating a course verbatim and re-using resources. The former is not recommended in a participant-centered plan. The latter is merely practical.

III. Three constraints on selecting what to teach are:

(1) laboratory equipment used in teaching is not always available at the actual work site, and participants will be unable to implement new techniques;
(2) work situations do not call for the use of new procedures;
(3) participants attend sessions for other reasons than to learn.

The related question of how much actual learning occurs in CPE was also raised. In some programs mere registration is sufficient for CPE credit. In other cases, participants may be there physically, but their knowledge is not increased (for such diverse reasons as lack of motivation, or knowledge already in hand.)

In general, professional clientele do not want to attend symposia on topics that are not very new. Advancement, not remedial activities, is the reason for CPE.

Some professionals want programs that center on special client groups rather than content areas. For example, CPE on cancer patients is well-attended by a variety of professionals as long as the specific topic is new.

IV. Another concern was with numbers of institutions offering programs. In Michigan for example, only one institution, the University of Michigan at Ann Arbor, is currently accredited to offer MCPE to the medical profession. A tremendous demand for services has been placed on that institution, with 25 hours per year required of each of 15,000 M.D.'s. The impact on program development is that planners must resort to large lectures. On the other hand, a very different problem exists in New York, where a large number of institutions offer programs. In this case, impact on program development concerns coordination and quality control.

V. Accountability was a further concern. Who, the professional or the training program, is liable in malpractice cases?

VI. Questions of costs and record-keeping for MCPE arose during the discussion. Costs are handled in different manners in different states. The full weight of costs may sometimes fall on participants. Other states may subsidize MCPE. There are hidden costs to the institution which provides CPE to its staff - person hours lost, replacement, and record-keeping.

The question of who teaches the teachers of CPE was also raised.

VII. MCPE for faculties is still theoretical. The issue has been raised at Mount Sinai Medical Center in New York, where the medical college faculty is opposed to it.

The CPE program developer has two separate tasks. The first is implementing programs that comply with the law - such as creating the treadmill to accomodate the large numbers of M.D.'s in Michigan. The second is finding ways to get off the treadmill. This includes assessing local resources and needs, educating faculty, and finding ways to individualize information.

These seven issues were raised. Their implications for program development were or were not made explicit, according to time constraints. Elaboration is inevitable as MCPE is studied further.

The topic merits a conference in itself, and only the skeleton was established during this workshop.

Notes prepared by
Rachelle Garcia de Soria and
Jeanette Holmberg

SYSTEMS FOR DELIVERING CONTINUING EDUCATION

John Thorpe, DDS
College of Dentistry
University of Illinois at the Medical Center

INTRODUCTION

Before one can intelligently discuss systems for delivering continuing education it would seem imperative to delineate in what context these concepts are to be perceived. Quite often when we think of a system for accomplishing a task we think of a closed one which acts independently, for the most part, of outside influence. The cardiovascular system bringing the blood supply to the brain might be considered in this perspective, although it is certainly responsive to outside stimuli.

On the other hand, we may have a more abstract concept of a system when we talk about the political system. In the latter, objectives are often unknown or ill defined and measurable quantities are not practical or they are elusive. The "system" exists by nature of the process and more often than not there is no planned input designed to insure a specific outcome. There is more reaction than pre-planned action.

Unfortunately, when talking about continuing education we often find ourselves considering both of the above concepts. Are we talking about a system that puts continuing education (whatever that may be) capability in the hands of practitioners in hopes that something happens? Or are we talking about a process in which both real and perceived needs are discovered, educational and behavioral objectives established to meet them, entrance potential measured, previously tested material presented and, finally, short and long-term evaluation in terms of delivery patterns which ensure quality of care for patients?

If we are speaking of the latter process, we are referring not to one system, but a number of sub-systems which when energized are planned to work in a synergistic fashion to achieve the desired results.

Continuing education in itself has not been specifically defined in too many institutions. This is probably because the process was seen as something that ought to be done, but in many instances was given little priority in terms of budget or administrative support.

This kind of activity, on the other hand, in some instances evolved into a sophisticated operation in which sub-systems do work together to achieve an outcome. Some of these activities might be:

a) needs identification system
b) program development system
c) marketing system
d) delivery system
e) evaluation system

Some brief comments are in order relating to these sub-groups that enter into the process we like to call Continuing Education.

Needs Assessment Sub-system The important element here is that real need versus perceived need be recognized when we are talking about insuring quality of care. Quite often a survey is used to determine needs. This is all right as long as the individuals recognize their areas of weakness as well as the knowledge they wish to pursue simply because of interest on their part. Determining needs also is dependent upon an evaluation of the learner's entrance behavior. There must be an assessment of what the person knows before courses can be intelligently prescribed which will fill that need.

In those instances where an individual feels that he knows what his needs are, there may be an element of bias which would prevent actual needs being accommodated thus assuring that the capability of giving quality care is objectively achieved. A better way to assess needs is to test for them. This may be done by the individual, including the evaluation, or it may be done by an objective party specializing in this type of work. The task is to determine the body of knowledge or the clinical skills needed at a given time to deliver quality care and test the individual against that norm.

In the past several years there has been a trend toward self-assessment. Professional medical and dental societies across the country are inviting and, in some instances, requiring their members to participate in such programs. There is a paranoia among some professionals that does not allow them to lay their competency on the line for the whole world to see. However, with the increase of third-party payment, evaluation of competency is becoming less of a prerogative of the individual.

One example of a sub-system for needs determination is the American College of Dentistry's program that is administered by the National Testing Service of New Jersey. It is interesting to note that this evaluation of knowledge was once done in very much the same manner as the Graduate Record Exam. However, it became necessary to change the format in order to allow the participant to grade his or her own examination because the level of participation was not adequate to support the program. Again, it is doubtful that third-party payers will tolerate this type of self-evaluation much longer since there is no assurance that the long-run societal needs in terms of care are being met.

This is a good place to mention that, although a universal system for delivering continuing education may be developed, it must be flexible enough to accommodate special facets of individual groups.

Dentists, for example, in contrast to physicians, are the recipients of a terminal degree in most instances. At the end of four years of professional schooling, the dental students are on their own and relatively free of peer review in their treatment of patients. This means that they must have a very high level of competency in the biological sciences combined with the necessary psychomotor skills the day he or she leaves dental school.

The physician, on the other hand, will have continued reinforcement or acquisition of new knowledge in clerkships and residencies. Later in their careers, they are subject to scrutiny in operating rooms and through the mechanisms of tissue audit committees and autopsy reports. Thus the physician's knowledge is continually being reinforced and continually a peer review mechanism is in process.

Consider this in contrast to the dentist whose educational process has taught him to be self-reliant, a "loner" if you will. For the most part he serves as his own internal medicine man, his own anesthesiologist, and finally he is the surgeon. In contrast also to many physicians, he "operates" on almost 98% of all of his patients, thus the critical need to assess psychomotor skills. Given all of these responsibilities, the dental student is pushed out the door with the admonition that he has only been given the basics; therefore it is imperative to continue his or her education on a regular basis. This is all compounded by the fact that dental medicine is a realtively new aspect of the professional and consequently new knowledge and techniques are making older elements obsolete on an almost day-to-day basis.

We have spent considerable time discussing needs assessment, but it must be remembered that this is perhaps the most critical sub-system. The other components of the system may be working well, but if the practitioners are not getting what they need to ensure capability (I use the word capability with specific purpose) of delivering quality care, then the entire effort may be considered nothing more than busy work.

Program Development Sub-system

Having knowledge of the desires and real needs of our constituency, we can then begin to meet those needs. This brings us to the next sub-system: the prescribing, if you will, and the development of the educational package which as objectives, those elements which relate to the previously determined needs. Here again is a critical component of continuing education, for if the material to be learned has not been tested for its reliability to convey the intended information, then the exercise is in vain! It is akin to the tale about the wonderful program developed by the military to allow pilots to learn via self-paced programmed instruction. It didn't take them long to realize that take-off and landing needed to be one unit of learning and not sequential. One can only agonize over the valuable hours of professional time that is spent participating in programs of questionable value. Fortunately, there are available in many disciplines educational packages that have been tested and proven to be reliable for attaining of specific objectives. In dentistry and medicine we find that undergraduate education is resplendent with sophisticated education packages for the learning of basic sciences. Certainly these same programs would be amenable to continuing education.

If a program does not exist which will meet the needs of an individual or a group, a custom course can be developed with the help of educational resources available in most educational institutions.

The Marketing Sub-system With the needs determined and the appropriate educational packages developed to insure the capability of meeting those needs, the next sub-system in the continuing education process is the marketing of the product. It is just within the last several years that some of us have come to realize that, as unprofessional as it may sound, we are in the selling business. Just as the practitioner must sell preventive medicine habits to his patients, so, too, must we sell our educational wares to the health care providers. It is disheartening to see a well developed continuing education course cancelled or have few in attendance because it was not properly marketed.

Briefly, good marketing includes:

a) sufficient advanced notice
b) proper audience
c) an attractive package
d) easy reply

The above are self-explanatory. Suffice to say that it is of sad consequence to have a well developed program meeting specific needs fail because the target audience was not notified sufficiently in advance to allow them to arrange their schedules to accommodate the program.

Tips on developing a marketing sub-system are best obtained from professionals, and a course in these methods or hours spent with a marketing consultant are well worth your time and money. The only caution is to remember that there are basic marketing principles, but often times a specific technique must be used for a particular group. For example, a mailing to "Doctors and Dentists" would immediately turn off a large segment of a somewhat paranoid unnamed professional group. Know your intended audience. This is perhaps one of the most important elements of successful marketing in professional continuing education.

The Delivery Sub-system Having assessed needs, planned and developed a program specific to those needs, marketed the program successfully, we come to the task of delivery. For those of you who have come looking for a "how to" system and have been disappointed thus far, I offer no hope at this point. My purpose today has been one of exploring with you what the system must consist of if it is to achieve its goal or, in other terms, what constitutes a viable delivery system.

I am sure there are many people here more qualified than myself to discuss such delivery mechanisms as closed circuit T.V., open educational T.V., C.A.I. (computer assisted instruction), self-paced programmed learning, audiovisual "books" for learning, "telephone learning" and the myriad of hardware systems for delivering the product. I feel somewhat akin to the man from Johnstown who, when meeting St. Peter, was told that his first responsibility in heaven would be to tell those gathered about dignificant events in their lives. "Great!" he said. "I always enjoy talking about our great flood." St. Peter cautiously said, "Well, that's O.K., but remember Noah is in the audience!"

I hope to elicit from you the effectiveness and the efficiency of these various delivery systems. It is my suspicion that there has been little research in cost effectiveness (at what cost was the job correctly done?) and in cost efficiency (was this the cheapest way to do it?).

The important point to consider when discussing delivery systems in continuing education is: does that system allow for attainment of the goal? It would appear that there is a multitude of continuing education courses offered throughout the country which either have no concise measurable objectives or there is an overabundance of courses whose goal is one of creating an awareness!

In dentistry, for example, a lecture-seminar on a clinical procedure can hardly be expected to deliver a clinican competent in that procedure. It may, but more than likely that practitioner will go home and continue his same comfortable routine.

I think too often we expect too much from a continuing education course. Is it reasonable to expect that we can alter behavior and introduce new clinical skills with a one-day continuing education program? I doubt it! It seems that we too often look to sophisticated hardware as a means of delivering continuing education with the expectation that this will be the magical mystique that will achieve the desired results, whatever, these may be.

Delivery is inextricably tied to goals and objectives and, as a consequence, must be studied in equal depth. An inherent part of delivery is often a person or persons and we must ask ourselves if these elements in the sub-system are compatible with getting the job done.

For example, and you will excuse my using dentistry so often, one of the foremost teachers of clinical dentistry in the country was asked to present an all-day seminar on clinical operative dentistry. Generally, he taught in small groups of four and would lay on the hands or direct the laying of hands under his close supervision. Someone thought that it would be a good thing to have this noteworthy clinician made available to greater numbers, hence a large audience turned out to learn about the latest techniques in dentistry. I am sure you know what I am going to say. The poor gentlemen was a total failure as he tried to do with a lecture what he did so well with demonstration and a few words. Thus it is apparent that the elements of the delivery sub-system must be considered when thinking of goals and objectives for the entire program.

Evaluation Sub-system This brings us to our final consideration of the evaluation sub-system. I will not go into a great deal of specifics here because it has been covered elsewhere. I only wish to pointout what is readily apparent, but often left out of continuing education programs. If you are going to expend resources to present a continuing education program, it would seem reasonablethat it should be evaluated in terms of something objective. Hoepfully, it would be evaluated in terms of very specific measurable objectives. It may have to be done in stages: short-term and long-term evaluation. If the objective of a program is to increase quality care and this is measured in terms of disease episodes in children or infant mortality rates, it may take some time to establish a cause and effect relationship.

There is often an attempt to over simplify when evaluating in terms of objectives. If the program has met the objectives, it is considered successful. The fallacy here is that the objectives may not be appropriate for the goals. The course could, in fact, be a failure.

As for mechanisms for evaluation, we need look no further than those used for evaluating any educational process. If, indeed, continuing education is to be education, then do not all of those requirements and caveats for a sound educational program at the undergraduate and graduate levels hold true for a continuing education program? Is the continuing education class not just that, a class which is entitled to the same input and outcome expectations as any other educational component in our institution? Probably the most important concept to remember is that quality continuing education does not necessarily insure competency and proven competency does not necessarily insure performance in terms of delivering quality care.

IMPACT OF MANDATORY CONTINUING EDUCATION ON A STAFF DEVELOPMENT PROGRAM

Jacqueline Schudel, R.N.
Carle Foundation Hospital
Urbana, Illinois

Mandatory continuing education appears to be a reality in the professionals' future, and nurses in Illinois are going to be very much involved in continuing education experiences. A program recognizing voluntary continuing education now exists in this state for the registered nurse. Regulatory mechanisms of this voluntary process have been established by the Illinois Nurses Association. For programs to be approved for contact hours by the Illinois Nurses Association specific criteria need be met. Educational objectives must be clearly defined, content of the program must reflect nursing involvement, the instructors' vitae must document expertise in the area being taught, and methodology of evaluation must be detailed. All of these criteria are then submitted to the Illinois Nurses Association for review and approval. The ability to design educationally sound programs leads us to our first concern regarding Staff Development's involvement in mandatory continuing education: what are the necessary qualifications to work in a Staff Development Department?

In virtually every profession that exists the question of clinical expertise versus educational expertise in program development can be discussed with varied opinions. Certain groups contend that if you know the correct methodology of program development you can write any program, even without much knowledge of the subject; others feel that knowing pertinent subject matter is most important.

The Staff Development Departments in the Champaign-Urbana area are primarly staffed with registered nurses. Their educational backgrounds reflect a basic nursing preparation, in additional to courses in continuing education and/or adult education. Personally, I find that an educational background and several years of actual clinical experience is a valuable resource.

Regardless of the preparation of Staff Development personnel certain problems, issues, and concerns will be present. Assessment of learning needs is essential to effective programming. Programs offered must be related to the identified needs of the institution and its employees. Other factors to be considered are: staffing patterns, centralized or decentralized approaches, and voluntary attendance versus required attendance. Carle Hospital's Staff Development activities are directed toward elevating the standards of patient care and nursing practice. Therefore our programs must relate to the delivery of quality care.

Alan B. Knox, states that "when a state requires that all active members of a profession must engage in at least a minimum amount of approved continuing education activities every few years to qualify for relicensure or recertification, there is a related obligation to make sure that a sufficient number of such activities are available, otherwise members could rightly say the rule is unfair." Consequently, sponsors other than staff development or in-service departments should also be considered: universities, community colleges, service institutions, and professional organizations should be committed to the sponsorship of relevant continuing education programs for nurses and other health professionals. Considering the number of registered nurses in Illinois, for example, and their varying levels of preparation, their range of experience, expected levels of competence and the mobility of contemporary society, we can see why so many institutions can and need be involved in presenting continuing education programs. Where should program responsibility rest?

Hospital Staff Development departments, as well as other medically related professions have a uniqueness in their program needs. Priorities must always center around ensuring competent practice in all aspects of nursing. Meeting the changing need of the institution brought about by technological advances is a constant challenge. The evaluation of the effectiveness of our efforts to address this challenge presents many concerns.

Most knowledge, attitudes, and skills acquired and applied in the clinical area will need to be evaluated not only immediately but also on a long term basis. Part of this evaluation should be peer review. It is very valid for the evaluation to be done by a colleague working in the same specialty field. Exactly how and when does the evaluation of behavioral changes, skill level, and application of knowledge take place? Is it at the completion of the program? Three months later? Six months later, or is it really measurable? Is indeed, mandatory continuing education really the answer to the concern for clinical competency?

Good working relationships and rapport must be established by members of a Staff Development Department with all levels of hospital staff. Each departments's role must be apparent as it contributes to the improvement of patient care. Head nurses and supervisors are willing to support programs if they have been directly or indirectly involved in the identification of learning need. Their subsequent pariticpation andevaluation will then be directed toward achievement of previously identified goals.

Mandatory continuing education places a great deal of responsibility on the individual, and the institution should provide an environment which fosters self direction. The sense of individual responsibility is an essential characteristic of a profession, but Staff Development must share in this responsibility of continuing education. Even though specific amounts of contact hours have been suggested to obtain relicensure, the Staff Development Departments should provide guidelines so that the nurses' continuing education participation will relate to her specialty area of practice and her identification of learning needs.

Efficient monitoring of individual practice requires structure as well as flexibility. Personnel must know what the institution expects of them, as well as what their personal goals for achievement are. Established guidelines must be written and communicated to every nurse.

Documentation of continuing education participation is essential. If Staff Development Departments are to be a resource for planning and guidance of continuing education for the professional nurse an accessible record of programs attended must be available. We use a Rolodex system. It is the responsibility of the registered professional nurse to notify us of all programs attended so they can be noted in our file. When we discuss Carle Foundation Hospital's Clinical

Ladder later in this paper, you will see why it is so important for us to document the continuing education programs.

Motivation has always been a difficult factor. What motivates one person does not necessarily motivate another. We are all familiar with this problem and could spend much time discussing this. At this time I would like to share with you the concepts underlying Carle Foundation Hospital's Clinical Ladder, which we believe help generate motivation as well as recognize the achievement of excellent practice. As the profession responds to a more sophisticated health care consumer, nurses must constantly strive to increase their knowledge and skills to improve the delivery of health care service. Preparation to practice in the expanding profession of nursing demands a basic theoretical background in the humanities, behavioral, biological, physical, and psychosocial sciences. The technical knowledge used in nursing practice has an identified half life of approximately five to six years and scientific knowledge is estimated to be doubling itself every twenty years.

[1]The main objective of the Clinical Ladder is to recognize and reward the nurse who is proficient in the art and science of nursing. Promotion traditionally has required a move into administration which often removed the nurse from all or part of her patient contact. As a result much of the personal satisfaction she desired from her nursing career was missing.

Since it was recognized that within the hospital structure nurses could have the opportunity for promotion in the clinical setting, the Clinical Ladder program was developed. The projected time to initiate the program is late spring or early summer. When this program is implemented each nurse employed at the hospital will choose career direction and aspirations. As you can see on Table I, graphic portrayal of the clinical ladder, we have shown all three basic educational preparations of the registered nurse, denoting the fact that every nurse has an equal opportunity to achieve the goals of her choice.

On the diagram, Nurse Practitioner I can be considered to be capable of assuming responsibility for total nursing care. This level is equated to the beginning nurse or a nurse with less than six months of clinical practice. As she progresses toward Nurse Practitioner II, she will be able to begin primary nursing. The basic premise of Primary Nursing is that one staff nurse assumes principal responsibility for the care of a number of patients. The nurse will decide what care they need, how it will be given and shall be held accountable for carrying out the care. This is based on a 24-hour decision making process. As you can see qualities possessed by the Nurse Practitioner I include reliability and adaptability.

Each level of the Ladder will require the nurse to attend a minimum of 10 hours of continuing education to maintain her current status. If continuing education becomes mandatory, we will adjust our requirements to coincide with the legislation.

For a nurse practitioner to be promoted both specific and general criteria must be met. General criteria refers to basic standards of practice. Each unit at our hospital is a specialized unit, and must have individual performance criteria relating to that specialty service. These performance criteria will be used for evaluation as well as for the promotion process.

Nurse Practitioner II will practice as a Primary Nurse, possessing the three A's that are equated with primary nursing. Those being AUTHORITY, AUTONOMY, and ACCOUNTABILITY. She will also achieve the level of practice as identified in the performance criteria for level II. The competion of 45 contact hours of continuing education over a two year time span is required.

Nurse practitioner III requires a significantly higher level of practice. This nurse is a Primary Nurse, a consultant, a teacher, and clinical investigator, and she must also exhibit qualities of leadership. Two years in the area of clinical specialization must be completed, and she must have accumulated 55 contact hours of continuing education in that same period.

In both Nurse Practitioner II and III one-half of the acquired continuing education hours must be related to the nurses' area of specialty practice. This will help to insure an elevated standard of nursing practice.

The Nurse Specialist will work in the High Risk areas, such as, Neonatology, Intensive care units, and Operating Room. She must complete a formal course in Physical Assessment, and demonstrate use of this knowledge in the care of the patient. The completion of two years of practice in a specialty unit is a prerequisite as well as meeting the identified performance criteria for this level. Other requirements are the ability to develop innovative approaches to patient care as well as anticipating and evaluating potential crisis situations.

Promotion up the Clinical Ladder is not automatic, the nurse who wants to advance must fulfill all requirements and petition a review board. Documentation of required continuing education and a summary of clinical performance will be submitted to the board for consideration of promotion.

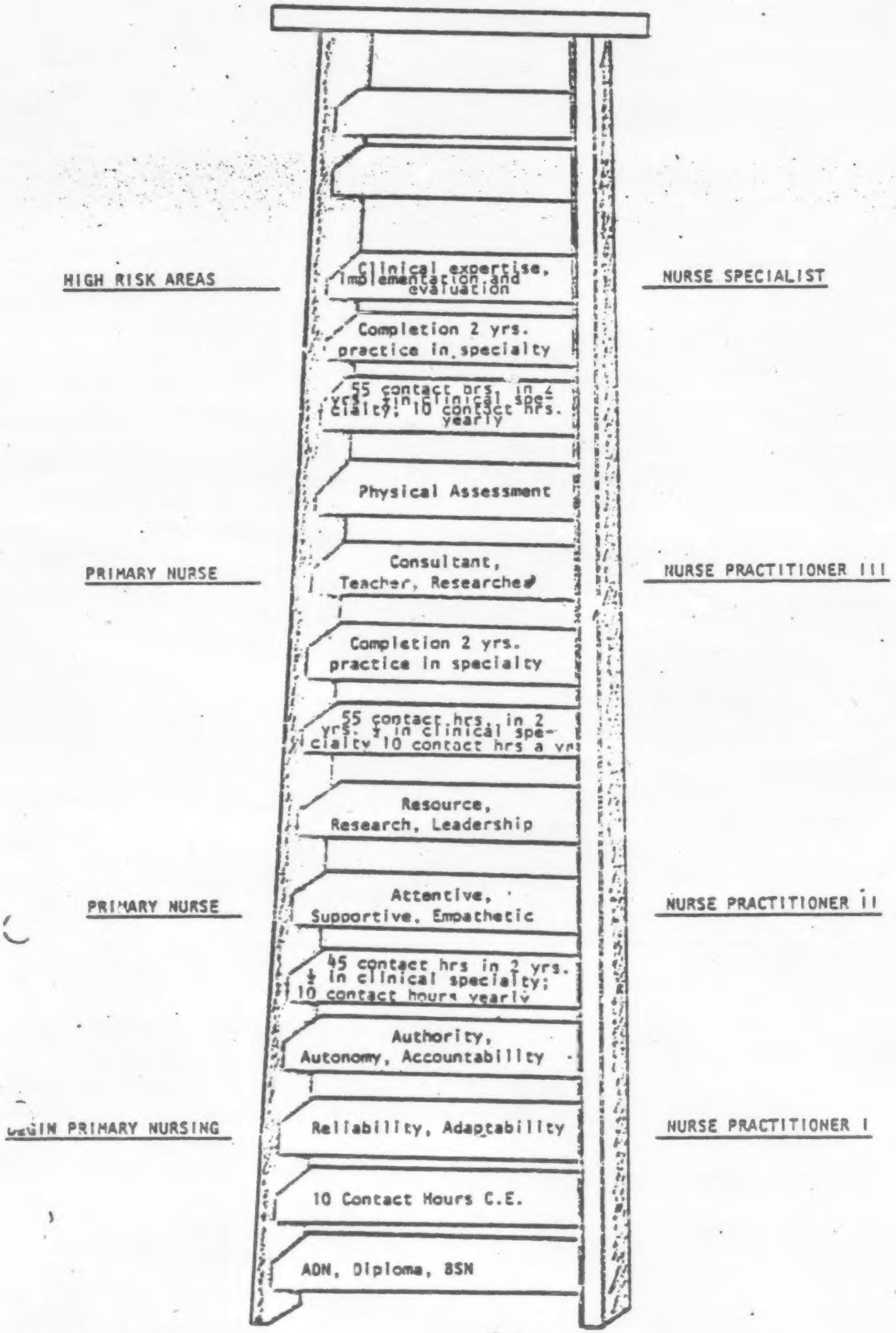
The concepts presented reflect Carle Foundation Hospital's objectives and philosophy for continuing education of nursing practice. We believe nursing practice, continuing education, and quality patient care interface smoothly within a planned structure.

---

[1] Copyright has been applied for. This material may not be reproduced without permission form Carle Foundation Hospital Nursing Serivce.

Carle Foundation Hospital

CLINICAL LADDER


HIGH RISK AREAS
NURSE SPECIALIST
Clinical expertise, implementation and evaluation
Completion 2 yrs. practice in specialty
55 contact hrs. in 2 yrs. ½ in clinical specialty; 10 contact hrs. yearly
Physical Assessment
PRIMARY NURSE
NURSE PRACTITIONER III
Consultant, Teacher, Researcher
Completion 2 yrs. practice in specialty
55 contact hrs. in 2 yrs. ½ in clinical specialty 10 contact hrs a yr
Resource, Research, Leadership
PRIMARY NURSE
NURSE PRACTITIONER II
Attentive, Supportive, Empathetic
45 contact hrs in 2 yrs. ½ in clinical specialty; 10 contact hours yearly
Authority, Autonomy, Accountability
BEGIN PRIMARY NURSING
NURSE PRACTITIONER I
Reliability, Adaptability
10 Contact Hours C.E.
ADN, Diploma, BSN

"ASSESSING NEEDS FOR CONTINUING EDUCATION"

Robert P. Means
University of Illinois at Urbana-Champaign

The following statements are intended to serve as a review of the tasks the planner of continuing education activities should consider in the development, implementation, and evaluation of educational need assessment techniques.

1) Determine the specific target population(s) to be addressed. The types of information to collect and to a certain extent the techniques employed in the collection process are dependent on the target population(s) to be assessed.

2) Determine what types and how much information to collect. Collect only that information which will assist in the identification of needs and development of educational activities preferred by those persons assessed. In many instances, the assessment process motivates those assessed to engage in learning activities because they become conscious of areas in which there is need to increase competence and improve performance. Limiting the scope of the assessment to those areas of need in which a sponsor(s) is capable of developing educational activities reduces the chances that the assessment process will raise expectations of those assessed that there will be educational activities provided for all the identified needs.

3) In the actual design of a need assessment technique there are a few times, if any, when it is necessary to "reinvent the wheel." A review of the literature on educational need assessment will reveal the availability of numerous approaches. In addition, the use of an advisory committee, or panel of experts consisting of academicians, practitioners, and specialists from a particular profession, can provide valuable inputs as to the type of information the need assessment technique should include for collection.

4) Involve numbers of the target population(s) in developing and pilot testing the need assessment technique. The more that potential respondents are involved in the development the more opportunities one has to determine the validity and reliability of a technique for these particular target population(s). In addition, those that are involved in the planning are likely to participate in the actual assessment process and engage in educational activities that result from the assessment. Their involvement may even encourage their peers to participate.

5) The need assessment process should not only concentrate on determining the specific educational needs of the target population(s) but in addition, provide information that will assist the planner, in shaping subsequent educational activities, by identifying respondents preference for types of continuing education; preferences for the location, duration and scheduling of activities; and factors within one's work environment that are likely to facilitate or limit participation of the professional.

6) Once the educational needs are determined the planner should concentrate on prioritizing needs. It is seldom possible to provide educational

activities for all those needs identified in the assessment process. Selection of the most critical needs of the professional can be based on comparisons between job tasks which demand the greatest portions of the processing time and for which the professional indicates the greatest needs for continuing education activities.

7) Efforts should be made to translate the findings from the need assessment into short and long range educational activities for the professional. Using case studies, portrayals, formal reports, etc., the planner of continuing education activities should demonstrate the types of educational activities that might be developed by the individual professional, the organization for which the professional works, the professional associations, and other sponsors of educational activities, e.g. higher education institutions to coincide with the areas of identified need. The planner can use examples of ongoing continuing education activities in his/her own field and those activities developed in related fields that might serve as relevant examples.

8) Need assessment should be used as a continuous process in the development of educational activities. Development of an initial need assessment activity should include provisions for describing to others the specific procedures used so that this information might assist them in the development of future assessments. In addition, the planner of continuing education can use findings from the evaluation of programs as a basis for determining what educational needs were not addressed during a program and what additional needs surfaced as a result of the program. In short, the findings from program evaluations can serve as a first step in identifying needs of the professional for future programs.

VI

IMPLICATIONS FOR THE FUTURE

MANDATORY CONTINUING EDUCATION FOR PROFESSIONALS: IMPLICATIONS FOR THE FUTURE

Alan B. Knox
Continuing Education
University of Illinois at Urbana-Champaign

Some major issues regarding "mandatoryness" confront many of us who conduct continuing professional education programs. These issues are reflected in the growing literature on mandatory continuing education, and they emerge even more clearly when those engaged in continuing education related to a variety of professional fields gather to discuss their concerns.

Seven issues seem to be most prominent. The purpose of this statement is to explore implications of these seven issues for those who plan and conduct continuing professional education programs. The implications deal with our understanding, response, and leadership regarding proposed or actual requirements that continuing education be mandatory, especially when such requirements are designed to protect the public from substandard performance by a small minority of practitioners in a professional field.

1. EACH PROFESSION AND THE PUBLIC HAS A RESPONSIBILITY FOR PROFESSIONAL COMPETENCE

Both individual professionals (including their associations) and the public (including legislatures and governmental agencies) have a stake in the quality of professional competence and service, and both of these two interests should be included in an effective approach to continuing professional education. Their complementary contributions should be reflected in both policy committees and planning committees for continuing professional education. In many professional fields, it might be useful to conduct continuing education programs that have as their topic the desirability and feasibility of inclusion of people from outside the profession on policy and planning committees regarding continuing professional education. Educational institutions as sponsors of continuing professional education programs have a special obligation to provide a neutral setting in which issues, such as "mandatoryness" or public representation, can be discussed in a forum in which both professional and public interests are included.

2. THOSE WHO CONDUCT CONTINUINNG PROFESSIONAL EDUCATION PROGRAMS HAVE A RESPONSIBILITY TO DEAL WITH POLICY ISSUES

Those who plan and conduct continuing professional education programs should gain some satisfaction from the steady increases in the extent and variety of programs available. Each year, about half of the members of most professional fields engage in at least one continuing education program. This participation includes study of both work-related and non-work-related topics. This impressive record of expansion reflects both increased demand in most professional fields and leadership by planners. One emerging part of this leadership responsibility is a better understanding of policy issues such as "mandatoryness."

A better understanding of issues related to social change, obsolescence, and required programs should provide a perspective from which program planners can take the initiative on behalf of desirable program emphases and arrangements, and not just react to external forces. Program planners should clarify for policy makers and others the contribution of continuing education in relation to preparatory education and entry into the profession, along with the work environment and individual ethics that also influence professional performance. They should also alert others to the likely impact of proposed requirements related to continuing professional education.

3. THERE ARE BOTH ADVANTAGES AND DISADVANTAGES OF MANDATORY REQUIREMENTS

The range of continuing education activities, which includes those that are self-directed as well as those that are externally-sponsored, provides a means by which members of a profession can effectively increase their competence. It seems desirable to encourage all members of a profession to continue to increase their competence throughout their career by use of various methods. However, participation in continuing education by all members of a profession would provide no guarantee against substandard performance by a few. The advantages of using mandatory requirements to encourage some members of a profession to participate in more continuing education than they otherwise would, and to provide some reassurance to the public, should be compared with the likely disadvantages. This comparison for each field can help members to decide if, on balance, mandatory requirements are worthwhile or at least to recognize some of the hazards of mandatory requirements so that they can be minimized.

Listed below are the major disadvantages of trying to use mandatory continuing professional education to try to protect the public from substandard performance by unqualified personnel who have not kept up in their field.

a. To be responsive, mandatory continuing education programs would have to be tailored to the extreme specialization that occurs during professional careers. Unless available programs reflect this specialization, requirements that all members engage in approved programs that are more general tend to be unproductive.

b. The approval process tends to centralize continuing professional education and to discourage desirable diversity among sponsors. This can reduce innovation by both individual professionals and sponsors of continuing education.

c. Efforts to minimize substandard performance by a few professionals creates undesirable defensiveness by many members who feel that they have been coerced to participate in the resulting mandatory continuing education programs.

d. If sufficient resources are devoted to the provision of programs to meet minimum requirements, there may be little left over to assist the more able members to extend their competence. Studies of diffusion and adoption of innovative practices indicate how influential their example is on other members, some of whom would be far less influenced by abstract information.

e. If the reason for mandatory requirements is to affect service to the public, then evidence of participation or even competence is insufficient. The methodological and political problems of assessing the actual performance of practitioners remains. One way to reduce the expense of and resistance to performance review is to use inexpensive procedures to identify members whose performance is likely to be substandard and then to use more extensive procedures to document the specific areas of substandard performance that may exist.

f. The problem of enforcing participation in continuing education as the basis for relicensure is about as great as the problem of disciplinary action for substandard performance.

g. If mandatory continuing education is a token solution to the problem of substandard professional performance, it discourages the search for more effective solutions.

If the hazards related to mandatory requirements are not frankly recognized, the public may be led to expect that mandatory continuing education will serve to detect and correct substandard performance by some professionals. When this unlikely benefit fails to occur, there is likely to be a backlash that will damange all of continuing professional education. The widespread negative attitudes of school teachers regarding required in-service days provided by the school system and university credit courses required for recertification illustrate this problem.

4. MANDATORY CONTINUING EDUCATION REQUIREMENTS MIGHT SERVE AS A TRANSITION ARRANGEMENT

Some professional fields have proposed that mandatory requirements be a short-term arrangement until more effective solutions emerge for the problem of substandard performance. Proposed transition arrangements include requirements such as:

a. a minimum number of contact hours each year in approved programs and activities as a pre-condition for relicensure;

b. prior approval of continuing education programs that qualify;

c. accreditation of providers of continuing education; and

d. continuing education to prepare for periodic re-examination.

Those who plan and conduct continuing professional education programs should make sure that such transition arrangements do in fact lead towards more satisfactory long-term solutions in which continuing education is used to increase competence, and in which separate procedures such as monitoring, performance audit, and peer review are used to detect and correct substandard performance. In my opinion, progress by professional associations and state licensing boards on such long-term solutions should be the quid pro quo for collaborative arrangements that include mandatory requirements for continuing education as part of a transition arrangement.

5. PROFESSIONAL STANDARDS SERVE AS AN IMPORTANT BASIS FOR BOTH QUALITY CONTROL AND CONTINUING EDUCATION

The members of each profession, with some participation by people outside the field, have an obligation to specify major areas of practice along with standards of competence, and procedures to assess performance. Although preparatory education and examinations for entry to each profession should also reflect these standards, the entrance requirements tend to focus mainly on theknowledge base and to reflect little of the details of practice, specialization, and ethics, all of which pertain to instances of substandard performance for those already engaged in each field. The desirability of some consistency of standards among states for these providers of continuing education that sponsor programs for practitioners from various states, indicates why national professional associations should assume major leadership in the specification of such standards. In a few fields, the associations of practitioners and of professional colleges have cooperated with an institution competent in testing and assessment to identify important competencies of practitioners as a first step toward the specification of standards. In addition to the evident utility of such standards for recertification and quality control generally, they would be very useful for needs assessment and setting priorities for continuing professional education.

6. MULTIPLE ARRANGEMENTS AND SPONSORS PROVIDE A VALUABLE RESOURCE BASE

Various sponsors of continuing education (such as associations, universities, and employers) provide complementary resources and contrasting perspectives, so an effective overall approach to continuing professional education should be pluralistic, including separately sponsored and co-sponsored programs. Both formal externally sponsored continuing education programs and informal self-directed study make unique and important contributions to increased competence, so an effective approach to continuing professional education should include provision for each. Voluntary participation by professionals in continuing professional education programs has enabled individuals to flexibly select and withdraw from programs, which has served to keep programs relevant and responsible. If an approach to continuing professional education does not include voluntary participation, then some other means should be used to provide responsiveness and flexibility.

7. SUCCESSFUL EFFORTS DEPEND ON EFFECTIVE PROGRAM DEVELOPMENT

Those who plan and conduct continuing professional education programs for all types of sponsors (such as associations, universities, employers) have much to learn from each other. Much of this sharing revolves around the process of program development. The basic components of program development are similar regardless of sponsor or field. These components include relating to setting, understanding of client needs and characteristics, selecting high priority objectives, effectively organizing learning activities, and evaluating to acheive program improvement. There is an urgent need for research and evaluation studies regarding the impact of continuing education programs on professional performance, including the benefits to clients. A helpful starting point in this regard would be to review the various forms of assessment now in use and to provide guidance to program planners regarding how to use them effectively, along with the advantages and disadvantages of each.

There are of course other issues related to mandatory continuing education and other implications for those who plan and conduct continuing professional education programs. The purpose of this statement was to encourage those engaged in continuing education programming related to each professional field to examine the policy issue of mandatory requirements as it relates to their field and to encourage colleagues to explore implications for action. To the extent to which this overview stimulates a critical appraisal of mandatory continuing education purposes and practices, it will have served its purpose.